



Alberta Medical Association
Committee on Reproductive Care

A Celebration of 70 Years of Vision and Action

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CHAPTER ONE

Alberta Medical Association Committee on Reproductive Care

A Celebration of 70 Years of Vision and Action

Nearly 70 years ago, dedicated Alberta doctors, nurses and other caregivers began a unique experiment to improve the health and safety of pregnant women and newborn babies in the province. These professionals toiled in private through successive generations, working on committees that were little known to the public: first the Committee on Maternal Welfare, formed in 1936; and then the Committee on Perinatal Mortality, which began work in 1954. These two committees merged in 1984 into the Alberta Medical Association's (AMA's) Committee on Reproductive Care (RCC).

Throughout all the years from 1936 to 2004, the committees collected a storehouse of information about pregnancies and maternal and infant health, and compiled it arduously. As a result, Alberta to this day has one of the most complete and accurate databases on pregnancy and maternal health in the world, and impressively low rates of maternal and infant death and illness.

Indeed, the AMA showed that it believed in Total Quality Improvement. The RCC didn't just study illness, but worked tirelessly to understand and prevent it, helping to improve service in remote areas where babies were dying for want of prompt care. The RCC fought for better transportation, sanitation and education. It examined all relevant illnesses and every single death to discover what might have been done better.

"The RCC was into Total Quality Improvement before it became a business fad," said Pemme Cunliffe, Director of the RCC after the retirement of Rachel Tasker, who worked for 30 years with the original committees and the RCC.

"We started calling it a quality assurance committee because that seemed to fit. We were really doing that all along. People did the work of quality assurance but didn't market it that way."

Dr. Leonard G. Evenson says: "It was always Total Quality Improvement at RCC . . . Ours was one of only a very few provinces that did a total review of total mortality. The western provinces did the best job in that area." Dr. Evenson was involved for many years, both on the RCC and as chair of the earlier Committee on Maternal Welfare. He continued his work with the RCC as a consultant.

Now the venerable RCC has been rolled into a provincial initiative that was inspired, in large measure, by its decades of dedicated service. The Alberta Perinatal Health Program came into being on July 1, 2004, as a four-way partnership among Alberta Health and Wellness, the AMA, the Calgary Health Region and Capital Health. The RCC continues as a major contributor, but within a program that has the full

involvement of the province's two major health regions, rather than functioning independently as in earlier years.

With the beginning of this new era, the AMA is proud to celebrate the achievements of these quiet, low-budget groups that helped improve the health of mothers and babies not just in Alberta, but across Canada. For several decades there was nothing else like them in the country; and when other provinces began their own programs, the AMA's model was frequently the one they followed. At conferences in the US and Europe, physicians often said that Alberta's work ranked with the best in the world.

The record of health improvement over the decades is little short of astounding. In 1955, 25 babies were dying in Alberta for every 1,000 births. By 1998 the figure had dropped to 5.2 of 1,000 – a fivefold decrease.

The statistical improvement in maternal survival was almost identical. In 1960, 4.9 women out of 10,000 died during pregnancy or while giving birth. By 1998, the figure was 0.8 maternal deaths per 10,000 births. Once again, this was a fivefold reduction in deaths.

Modern techniques, as well as the use of antibiotics and other new treatments, played a role in this sharp reduction. But Alberta's rate of decline was the steepest in Canada, and for many of these years the death rates were also the lowest in the country. For this, the AMA committees deserve a great deal of credit.

“Nationally, people look at the AMA as a leader in many ways,” says Dr. J. Guy Gokiart of Westlock, the first chair of the RCC. “We garner credit for being proactive. The RCC was something I relished when I was doing it. We were trying to do the right thing at the right time.”

Dr. John J. Boyd, another committee member, points out that all the members worked without pay. Nor were the committees themselves lavishly funded. The first grant to the earliest group, from the Federal Government, was just over \$2,000. The AMA contributed much to the budgets over the years. So did the province, which always encouraged the work. But the financial challenge became especially difficult after 1994, when the government cut spending in almost every area to reduce the deficit.

Yet the committee took on ever more tasks even as budgets stagnated. The dedication of the members never flagged, whatever the circumstances; more than one physician quietly paid expenses out of pocket to ensure that the work wasn't compromised. “All these services were provided gratis, and willingly,” Dr. Boyd emphasizes.

“The main strength was that it was a committee of peers that had acquired a quality-control function with respect to pregnant mothers and babies,” says Dr. Philip C. Etches, who was involved for 10 years both as a committee member and chair.

The government, recognizing how tricky this job could be, accorded legal privilege to committee deliberations and interviews under the *Alberta Evidence Act*.

This protected members from lawsuits by doctors, patients and families, and allowed them to pursue their single goal of improving health. The committee was also mandated by direct ministerial order to study: the deaths of women during pregnancy, delivery or post-delivery; stillborns after 20 weeks with a weight of 500 grams or more; and the mortality of newborns less than one month old. Meetings had to be held in strict privacy and identities were always protected; but the committee was allowed, and always eager, to share its wider findings with the government and the public.

From the very beginning, in 1936, the committees were avid collectors of statistics, believing correctly that trends in the numbers provided vital clues to helping individuals. Miss Tasker was a fiend for statistics, diligently collecting, collating and analyzing data whose significance had previously gone largely unnoticed.

The result, says Ms Cunliffe, is: “A great historical database of maternity care in Alberta. There is a continuous, complete file of all perinatal and neonatal deaths. It is the best database in Canada if not the world, and it spanned a period when there was such tremendous change in care for mothers and infants, and change in mortality rates. It started at a time just as antibiotics were becoming prevalent.” After her service with the RCC, Ms Cunliffe became a lawyer who sometimes provides expert advice to the AMA on legal matters.

The prime concern of the members was always people rather than numbers. They dug into the individual cases, interviewing physicians whose patients had sickened and died, always asking: How can this be done better? What went wrong? How can death and illness be avoided? The task was often emotional and painful for doctors who were questioned after they lost a patient. “The physicians did have a certain degree of discomfort,” says committee member Dr. Charlene M.T. Robertson. “Nobody took it lightly. They knew the RCC was right.”

Most physicians realized that the RCC was striving for improvement and prevention, not retribution. The burning mission of its members was to reduce maternal and infant deaths to the lowest level possible. “RCC was in the vanguard,” says Dr. Carolyn A. Lane, the last chair of the RCC. “It had to be; the mandate was healthy babies and healthy moms.” Nobody could quarrel with this ultimate motherhood issue.

Most deaths examined by the committee were found not to have been preventable. Others could have been avoided with better access to prompt care, especially in the rural north. Very occasionally, a doctor was found to be in error.

“There were times where someone misinterpreted information,” according to Dr. William R. Young. “There are times when bad things happened and you said ‘There but for the grace of God go I.’ ” In all these rare cases, the doctors involved were closely counselled and information was issued to ensure that nothing similar ever happened again.

In the vast majority of cases involving maternal or infant death, the doctor was blameless, but no less devastated. “People did the best they could and there was not very much they could have done to change anything,” Dr. Young says. Such cases were as tragic and difficult to avoid as car accidents. The committee’s role at these

moments was “to reaffirm that everything possible was done and they (the physicians) were treated reasonably.”

Dr. Lane says, “There was never any recrimination, just a spirit of cooperation rather than confrontation. The sole purpose was bettering the health of mother and baby.”

Everyone involved in the committee over many years describes an atmosphere of rigorous analysis, tough questions, vigorous debate, long hours and, often, fun.

“People always got along,” says Ms Cunliffe. “There were mainly men on the committee – women were just starting to come into medical practice. My first lesson was in how men communicate and work; they can disagree and then have lunch together.

“I don’t remember animosity, but certainly there was spirited discussion. And when the meeting was over, so were the feelings.”

“There wasn’t much agenda building. They came because they were interested. It didn’t further their own career; people sat on that committee for the right reasons. That’s why they were able to get so many things done.”

Dr. Fawzy H. Morcos recalls: “The RCC was fun. It took innovative approaches and tackled hot button topics. These were very challenging and controversial issues. I kept pushing. Although I didn’t always succeed, I was given the floor even if they didn’t see what I saw at the time.”

Dr. Etches points out that the committee’s mandate and activities were rare for a provincial medical association. “The quality control function isn’t necessarily a function of a medical body,” he says. “Essentially the AMA is a doctors’ organization. Its main *raison d’etre* was to preserve the well-being and status of doctors within the community and political structure, performing a number of functions, one of which was quality control.”

Ms Cunliffe points out that in other provinces, the colleges of physicians and surgeons usually take this role. But in Alberta, “the AMA, to their credit kept it, for good reasons. They wanted to be a professional body concerned with quality of work.” And they saw the merit in separating quality control from the physicians’ disciplinary body. With the sole mission of getting at the truth and ensuring the errors were never repeated, they were better able to deal with all parties in a non-threatening way.

Safe childbirth and happy outcomes are usually taken for granted in Canada today. Often we forget that in an era of less sophisticated imaging and diagnosis, before antibiotics were in common use, pregnancy was a time of uncertainty and fear. Mothers and children died far too often.

The RCC pulled together the collective expertise of Alberta’s medical profession to reduce the relatively high number of infants dying at birth or soon after. The statistical and anecdotal record contains ample proof that this is one of the greatest success stories in the history of Canadian medicine.

The committee's triumph is a testament not just to medical skill, but to the tenacity and diplomacy of people taking a sensitive and emotionally-charged situation and changing perceptions while vastly improving women's health.

Ultimately the committee had a profound effect on the quality of childbirth in Alberta and Canada. Alberta doctors and their colleagues led the way across the country in care for babies and mothers.

The AMA archives for the RCC are a treasure trove of statistics and case studies. They are also a tribute to the compassion of the many people who sat on the committee, all with one heartfelt goal: healthy mothers and healthy babies.

This is the story of the committee and its predecessors, the remarkable people who served on them, and their profound positive impact on the well-being of mothers and children.

CHAPTER TWO

Lifting the Veil of Ignorance: The Committee on Reproductive Care Works for Change

The Alberta Medical Association's (AMA's) Committee on Reproductive Care (RCC) was never shy. Over nearly 20 years, its revolving group of members confronted every key issue involving reproductive health, vigorously stating their opinions and pressing for change, even if they risked outrage from political and religious groups. Their key goal was always the same; ensuring the highest level of safety and health for mothers and babies.

The earlier committees, although equally opinionated about the social consequences of health care, had confined themselves more closely to examination of maternal and infant death. But once they were rolled into the RCC in 1984, the mandate began to grow, with full approval from the government.

Specifically, the group began to examine morbidity, or illness, of both mothers and babies. The first report of the new committee made this clear in 1985: "Because of the progress made in obstetric and neonatal perinatology, examining mortality outcomes is no longer adequate to ensure quality care; therefore, the committee has been examining parameters for examining morbidity." Later the report added: "This represents the breaking of completely new ground for the Committee on Reproductive Care in a departure from the previous work of the Perinatal Committee. As such, it is very complex and the work has just begun." The committee also signaled its intention to upgrade the quality of care by getting more involved in education.¹

Under the RCC chair of the day, Dr. Richard G. Chaytors, the committee was signaling a seismic shift in its mandate. By examining every area of maternal and infant health, it would sail directly into the most turbulent social and political waters of the 1980s and 1990s, tackling HIV/AIDS, birth control, high rates of teen pregnancy and sexually transmitted diseases, education for physicians about teen sexuality, universal sex education, and many other controversial issues. No matter how stormy the seas, the firm hands on the RCC tiller never wavered; they always steered directly toward the best health for girls, women and babies.

One of the most controversial issues was sex education in Alberta schools, a subject of fierce debate starting in the late 1970s. Dr. Donald E. Chadsey recalls that the RCC's predecessor, the Committee on Maternal Welfare, with others from the AMA Board of Directors, met with Alberta government ministers and education representatives.

¹ Committee on Reproductive Care Annual Report, 1985. The committee typically produced full annual reports and shorter, condensed versions that were presented to the AMA's annual meetings. The full reports were also printed for limited distribution. This history draws on both types of reports.

Although there was often lively discussion within the RCC, the committee publicly endorsed universal sex education. In 1987, after noting the province's high rate of teen pregnancy and sexually transmitted diseases, the committee staked out the ground clearly in its annual report:

“The Committee would like to see mandatory sex education in all schools in Alberta, giving only the parents the opportunity to opt out of this program. Currently school boards, individual schools and individual teachers are given the option of presenting the information.”²

The recommendation was highly controversial, drawing the ire of groups that objected to “teaching sex” outside the family. They wanted no change from the patchwork system that allowed both schools and teachers to refuse to teach sex education. A large proportion of Alberta students received no education about sexuality, and in some programs that did exist, the teachers were ill-prepared to instruct students.

Later in the same 1987 report, the committee urged that the AMA, “because of high rates of hospitalization for PID (Pelvic Inflammatory Disease) and escalating rates of ectopic pregnancy, actively encourage education in the effective use of the condom in conjunction with other forms of birth control, including oral contraceptives, in order to provide protection against pregnancy and to help decrease the incidence of sexually transmitted diseases among adolescents and young adults.”³

In 1989 the RCC once again deplored the declining reproductive health of Alberta teens. “Not only is the rate of pregnancy in this age group high, but so is the rate of sexually transmitted disease and ectopic pregnancy.” Repeating its call for universal sex education, the committee said: “The decision to opt out, and therefore not offer this part of the curriculum, should only be given to parents and not to principals or school boards.”⁴

The RCC never strayed from this conviction that only widespread, systematic education could stem a near epidemic of teen pregnancies, with all the attendant health and social problems.

The RCC was far from the only group lobbying for better sex education. Most Alberta health professionals were appalled by high levels of teen pregnancy and sexually transmitted diseases. In 1987, experts from health systems all over the province collaborated on an excellent report for Alberta Community Health. Called *In Trouble - A Way Out: A Report on Sexually Transmitted Diseases in Alberta Teens*, the report said bluntly: “We have given ignorance a fair trial and we are paying dearly. It is time for education. We cannot afford any other course.” The report detailed shocking levels of teen ectopic pregnancy, pelvic inflammatory disease, gonorrhoea and other sexually transmitted diseases – in every case, the highest rates in Canada.⁵

² Committee on Reproductive Care Annual Report, 1987.

³ Ibid

⁴ Committee on Reproductive Care Annual Report, 1989.

⁵ *In Trouble - A Way Out: A Report on Sexually Transmitted Diseases in Alberta Teens*, May 1987.

These facts alarmed Albertans, and the health professionals, often led by the AMA and the RCC, pressed on with their campaign for universal sex education.

The AMA and the RCC were always leaders, in part because of their unique role as an information-gathering agency. Constant pressure from the AMA had a huge effect on policy and made the government's political job easier. The RCC's science-based arguments, backed by compelling statistics, gave powerful authority to the case for widespread instruction in sexuality.

By the late 1980s, the logic and humanity of the AMA's position were already beginning to prevail. In June 1989, Jim Dinning, then the Minister of Education, introduced a policy that endorsed universal sex education. The minister issued orders under the *School Act* that human sexuality be taught in Grades 4 through 9, and in at least one year of high school. Only parents had the right to opt out, but schools were given flexibility in how they offered the material. Some existing family life or religion-based courses were endorsed for teaching what was now officially called Human Sexuality.⁶

The changes took effect in the fall of 1989 and they quickly had a tremendous impact on the reproductive well-being of Alberta teens. In 1989, when universal sex education began, there were 56.9 pregnancies for every 1,000 females aged 15 to 19 in the province. By 1993, the rate had dropped to 33.5 per 1,000.⁷

The social and health benefits of such a sharp decline in pregnancy are enormous; most teenage mothers drop out of school, lack job skills, and are at higher risk to give birth to babies with dangerously low birth weight.⁸ Avoiding teenage pregnancy not only saved the health system money, it also prevented a heavy load of human misery.

Nonetheless, the backlash continued for years. In 1991, a group called Teen Ed advocated delaying teen sex education and focusing on abstinence. The directors of the organization included the wives of two government MLAs. Under renewed pressure, Minister Dinning established a committee to review the sex education program.⁹

Despite the continued furor, the RCC didn't content itself merely with promoting sex education in the schools. In the same year the AMA went directly to the public, issuing a bright poster to alert teens that doctors were available for counselling on sex and contraceptives. Physicians received a booklet called *Go Ahead - Ask Me: A Physician Guide to Teen Sexuality Counselling* which helped them prepare for teenagers' problems and questions. This doctor's guide to sexuality counselling gave information on professional responsibilities, confidential billing codes, discussing sexuality with

⁶ The regulatory history of the program is still available on the government website at <http://www.education.gov.ab.ca/EducationGuide/pol-plan/polregs/412.asp>.

⁷ The 1989 figures are cited from federal sources in an *Edmonton Journal* article of May 13, 1992; the 1993 numbers are from a 1997 information sheet produced for doctors by the Calgary Regional Health Authority titled *Facts You Should Know about Teenage Pregnancy and Sexually Transmitted Diseases in Alberta and Calgary*.

⁸ Ibid

⁹ *Calgary Herald*, October 13, 1991.

adolescent patients, and preventing sexually transmitted diseases. (At the time, Alberta's rate of gonorrhea across all age groups was still the highest in Canada, 86.8 percent above the national average.) All these materials were discussed and developed by the RCC.¹⁰

This initiative brought a sharp reaction from some parents who believed that any sexuality counseling done without their knowledge was a violation of their rights, and those of their children. Newspapers were flooded with protest letters, especially in rural Alberta. But the complaints were becoming more muted as Albertans absorbed the shocking fact that provincial rates of teen pregnancy and disease were the highest in the country. Once again, the force and conviction of RCC members had provoked a major shift in public attitudes.

The battle was long and difficult, but universal sex education is now a settled part of the Alberta scene, routinely producing positive results with very little debate or opposition. For all that, the AMA's determined committee deserves a large share of the credit.

"We weren't just doing mortality reviews – there was a larger commitment to better reproductive health," says Grace Guyon, Manager of Reproductive Health and Special Projects for the RCC from 1991 until it was merged in 2004. "The committee took an advocacy role, for instance in sex education in schools, the Condom and Pill project, and advocacy around the adverse effects of alcohol on pregnancy."

"Essentially, people could bring issues to the table that need support to go to government for policy change or direction. Hence the committee went to the government and we developed a policy on HIV screening."

That initiative was another RCC success story. Within a short time, 97 percent of those who gave birth were being tested for HIV. Thirty-one women showed positive for the virus in the first two years. As Ms Guyon later said in a presentation to the government's Standing Policy Committee on Health and Community Living: "This means that we could get the necessary treatment to these women so that they could avoid transmission of the virus to their babies." The initiative not only improved the lives of HIV-positive mothers, but saved many of their children from shortened lives of pain and illness.

The RCC attacked with equal vigor the twin problems of alcohol consumption during pregnancy, and Fetal Alcohol Syndrome (FAS) in children. Through the Fetal Alcohol Partnership, the committee conducted a physicians' needs assessment that was later adopted by Health Canada for use across the country. It also developed clinical practice guidelines that were adopted by the prairie provinces and in parts of eastern Canada. Doctors were trained in prevention, harm reduction, and how to develop FAS diagnosis teams. Just as important, but saddest in its implications, the RCC facilitated training about FAS for staff members in young offenders' centres.

¹⁰ From *Go Ahead – Ask Me: A Physician Guide to Teen Sexuality Counselling*, Alberta Medical Association, 1991.

In the interests of maternal and infant health, the RCC also made itself politically incorrect during the 1980s by opposing a high-profile movement for home births. The AMA faced charges in the media that it was merely protecting doctors' traditional turf. But once again, the AMA was basing its conclusion on science and statistics.

The numbers always showed that home birth was vastly less safe than hospital birth. In 1986, the committee reported that the death rate for planned home births, corrected for anomalies, was 16.9 per 1,000. In one case, a baby died when an elderly midwife refused help from local authorities. All births, including the vast majority in hospitals, resulted in death rates varying from 6.0 to 8.4 per 1,000, depending on birth weight. The conclusion was clear and the committee stated it bluntly: "The perinatal death rate is high for babies born outside of hospital."¹¹

The RCC continued to recommend hospital birth, while encouraging midwives to play a role in obstetrical care. As Dr. Reginald S. Sauve notes: "The RCC supported midwives training in unison with obstetricians and working with obstetricians. They really supported them and their training programs so they could be part of the health care delivery team." In Edmonton, committee member Dr. Fawzy H. Morcos set up hospital-based midwifery programs in conjunction with the RCC.

None of this satisfied a vociferous home-birth lobby that often seemed to be based more on feminist theory than principles of sound health care. But it is difficult to imagine how the RCC could have created a fairer policy in the face of such powerful statistics on the risks of home birth.

The committee that wrestled with these complex, wrenching issues was a diverse group of up to 18 people appointed by the AMA. They included family physicians, obstetricians, pediatricians and members of other specialty groups the AMA deemed appropriate. The members came to several meetings a year from cities, small towns, rural areas and health regions all over the province.

"It was a very large group with a mix of private practice and academics, and general practice and obstetricians, and rural and urban, and they all had different constituencies that they represented," says Pemme Cunliffe, a nurse who directed the program for the AMA between 1984 and 1991. (Afterwards, Ms Cunliffe was an administrator at Edmonton's Royal Alexandra Hospital and then earned her law degree.)

"There were about four meetings a year, and leading up to those meetings there was lots of work putting together agendas and material.

"These were packed agendas with some very emotional topics. There was lots of controversy over some of the things we discussed.

"The meetings showed how much physicians really cared. They were always willing to consider new ideas and put aside some of the things they had been taught – for instance, why would you want a father in the delivery room? They were always prepared to examine some of their sacred cows."

¹¹ Committee on Reproductive Care Annual Report, 1986.

The RCC and its predecessors operated with the highest ethical standards. Ms Cunliffe recalls, for instance, that there was never any discussion of fee schedules or other subjects that involved the personal welfare of physicians. “The work of the committee was pure and focused on outcomes and care and betterment of health for mothers and babies. They never mixed their pay schedules with service – the two things were kept totally separate.”

There were sometimes lively discussions about issues such as therapeutic abortions or cesarean sections on demand. One participant recalls that on those occasions, when physicians brought both their training and personal convictions into the room, “the communications could be quite heated.”

Dr. Charlene M.T. Robertson remembers an “almost missionary desire to improve neonatal care.” The meetings were “collegial and collaborative. Everybody was committed to the concept of improving care. There wasn’t any room in the group for the notion that it’s God’s will that this mother and child are in trouble. It was all about seeing how we could help the individual physician, often in rural areas, give better care. . . . I have never heard anybody badmouth that committee. It is treated with huge respect.”

Dr. Sauve recalls, too, that the RCC was always “absolutely meticulous” about maintaining the confidentiality of both patients and physicians. This engendered trust that encouraged doctors to share their problems and experiences without reservation.

The bottom line, he adds, is that although the committee was composed of doctors, it was “aimed at patients – women and infants. The goal wasn’t to make doctors’ lives better. The goal was to make the quality of care the best it can be. That is impressive. And it’s part of the Alberta Medical Association.”

Dr. J. Guy Gokiart, a former RCC chair, says the meetings were usually “hard-working, energetic, task-oriented. They were always pleasant although sometimes held in jam-packed little rooms. The unpleasantness related to the review of cases and finding out what went wrong and having to tell a person to pull up their socks or tell hospitals they needed stronger reporting.”

Those situations arose when the committee examined deaths of mothers or infants, often with the attending physician in the room. No matter how heated the public issue of the day – whether it was sex education, abortion or any other controversial question – nothing caused as much painful emotion for committee members as the peer reviews of doctors whose patients had died.

These sessions often “tore at the soul,” says Dr. Sauve. He recalls one case, involving a doctor from northern Alberta, that resulted in “tears all over the place. I don’t ever want to be in a position with a patient coming to me with the kind of problem that doctor faced.” Dr. Sauve doesn’t divulge details or names; he isn’t allowed to, and wouldn’t in any case. But even his brief sketch conveys the awful dilemmas doctors sometimes face. Ms Cunliffe recalls: “Some of these RCC meetings were emotional. The physicians who came were often distraught because they cared so much.”

The RCC had full authority from the province to conduct these reviews. Its mandate included the following specific powers: review of perinatal, neonatal and maternal mortality cases; feedback to physicians following mortality reviews; identification of quality care issues; data management; forms development and revision.¹²

The RCC was empowered to monitor and report all perinatal and neonatal deaths of infants up to 28 days old, as well as the deaths of mothers during pregnancy or up to 90 days after childbirth.

When a death occurred, the hospital sent an “Alberta Study of Perinatal and Neonatal Death” form to the RCC, along with records and forms from the patients’ chart. The RCC’s reproductive health manager then “triaged” them, deciding if more facts should be requested, or if the information would be entered into the data system. The third option was peer review.

The forms passed on to the RCC by hospitals included: the Alberta Prenatal Record; Delivery Records Part 1 and 2; Notice of a Live Birth or Stillbirth (NOB); Newborn Record, Stillborn Examination and Investigation Record, Narrative Discharge Summary; Autopsy Reports; Placenta Pathology; Consultation Reports; and Neonatal Transport Records.

The RCC members were obviously well equipped to evaluate a case if they decided to call in a physician, a step that was taken only after very careful consideration.

“The Peer Review Process is an important part of the case reviews,” says the RCC document. “The Neonatal and Obstetrical Office Consultants decide which cases should go to Peer Review. Physicians involved in the cases going to Peer Review are contacted and can participate in the review if desired. The Peer Review process looks at whether the death was preventable or not preventable. They also assess whether the standards of care were met and if not, where the deficiencies existed. The Consultants then communicate the results to the appropriate individuals.”¹³

In the most serious circumstances (very few in number) the RCC passed on cases to the College of Physicians and Surgeons of Alberta for possible discipline. Once again, the criteria were strict. A majority of members had to agree to the referral, after considering these questions:

“Does the practice of a reviewed physician place patients at risk of inadequate care?”

“Are education and remedial action within the mandate of the committee not adequate to resolve the concerns?”¹⁴

¹² From RCC document included in a review of the RCC review process at a meeting held in Banff, February 2003.

¹³ Ibid

¹⁴ AMA Policy Statement, Article 6, approved by the AMA Board of Directors July 25/26, 1997 and revised June 1999.

If the committee decided to refer a case to the college, it did so through a letter with a copy sent to the physician, but not before making every effort to discuss the case, and the concerns, with the doctor in question.

At this stage, a crucial rule separated the RCC from the disciplinary process: The committee was not allowed to send any charts or other documentation about the case to the College of Physicians and Surgeons of Alberta.¹⁵ This in no way means that physicians were protecting each other; rather, it preserved the RCC's standing as a quality control group rather than a disciplinary body. Doctors who chose to appear before the RCC could thus be more frank and feel less threatened.

Usually, when medical errors had been made, the RCC resolved matters through counselling and education. The physicians were always devastated. Dr. Gokiart says: "We had to reassure them that they weren't lousy doctors. The educational and communication process was part of what we did. We had to make sure everyone was up to scratch. If anything went wrong, we were able to hold their hands and give them educational advice."

Dr. John J. Boyd recalls: "Meetings could become quite acrimonious if people felt they were being criticized. The aim wasn't to criticize but to find exact truth and discover how things could be improved. In obstetrics none of us wanted any mother and babies to come to harm – preventing that was our whole aim.

"Unfortunately it couldn't always be the case. Occasionally the same doctor's name came up and then the committee would have a word with him, but these were very rare occasions. There were a few doctors who completely refused, but most got completely involved."

Medicine is complex, and the majority of cases that escalate into tragedy begin with a small error or omission. Dr. Gokiart states the reality vividly when he says: "One or two little things go awry and disasters happen. Go back to NASA and that O-ring and seven people died. Here we see one misjudgment and a whole cascade of problems that can happen." With remarkable diligence over many years, the RCC sought out those potential "system errors" in order to eliminate them.

The focus on data, and the constant refining of reports completed by nurses and doctors, were ways of spotting those flaws as quickly as possible. The RCC was always encouraging doctors and hospitals to fill out these crucial but tedious forms. "The Committee is grateful to the physicians who take the time to complete the information that is so vital to our review," the RCC's annual report said in 1990. The declaration was repeated nearly every year for decades. But the committee and its predecessors could be stern when the forms didn't arrive. Rachel Tasker was famous for marching straight into laggard hospitals that were tardy with their paperwork. After one of her famous scoldings, they soon sent in the documents.

Because of the dedication of Miss Tasker and her successors, Ms Cunliffe and Ms Guyon, Alberta's database remains unmatched. "Our perinatal and maternal reports

¹⁵ Ibid

were second to none in Canada,” says Dr. Boyd. One reason was the absolute dedication of the three program managers; another was continuity. Only one manager was responsible for the data at any one time, and there were just three of them over the course of 50 years. Miss Tasker trained her successor, Ms Cunliffe, when the RCC began in 1984. In 1991, Ms Cunliffe in turn trained Ms Guyon.

The government aided this entire process, from information gathering to peer review, by according legal privilege to the RCC. This meant that documents given to the committee could not be subpoenaed as evidence. Nor could members be called to testify in court cases brought by patients, doctors or other health professionals. Doctors called to the committee often worried about legal consequences, but they had no cause for concern. Lawsuits might come from other directions, but never from the RCC.

“We had protection under the *Alberta Evidence Act* and also the *Hospitals Act*,” says Ms Cunliffe. “We were able to get access to the data, and those data were protected from being subpoenaed and lawsuits. So physicians were able to share very freely without worrying about the information showing up in court. Most people didn’t even know this review went on. Even if we wanted to give information to people outside, we couldn’t.”

But the process was delicate. Many health professionals instinctively balked at releasing sensitive personal information; consequently, the government sometimes had to reinforce the RCC’s right to collect data. In 2001, Health Minister Gary Mar issued a ministerial order to restate what had already been happening for decades. His order designated “the members of the Committee from time to time as entitled to receive maternal and perinatal records of diagnostic and treatment services provided to individuals in approved hospitals.” Then he clearly stated the RCC’s own obligations. The committee would get the information “provided always that such information shall be treated as private and confidential and shall not be published, released or disclosed in any manner that would be detrimental to the personal interests, reputation or privacy of a patient or the patient’s attending physician”¹⁶

As the health system grew more complex and legislation was added or changed, the guarantee of privilege under the *Alberta Evidence Act* also had to be adjusted and assured. In April 1999, the government enacted the *Quality Assurance Activity Statutes Amendment Act*, which amended both the *Alberta Evidence Act* and the *Freedom of Information and Protection of Privacy Act* (FOIP). As Deputy Health Minister Lynne Duncan explained in a letter to health authorities, as well as the AMA, “The amendments to the *Alberta Evidence Act* expand the evidentiary protection provisions currently provided to medical committees, to all quality assurance committees.” She reiterated that “the proceedings and records of all quality assurance committees cannot be subpoenaed or otherwise used in a court action, nor can the members of such committees be compelled to testify about their involvement in quality assurance

¹⁶ Ministerial Order #22/2001, Alberta Health and Wellness, Office of the Minister, January 31, 2001.

activities.” The legislation also removed quality assurance records from applications of disclosure under FOIP.¹⁷

There was another alarm when the government passed the *Health Information Act* on April 25, 2001. The AMA sought legal advice, asking if this new law compromised privilege under the *Alberta Evidence Act*. The answer was no, and the opinion was written by an articling law student named Ms Cunliffe.¹⁸

Ultimately, the test of the RCC was whether it did indeed promote and ensure quality care. The answer is resoundingly positive. During the RCC’s tenure, maternal and infant death rates declined, as did rates of teen pregnancy and sexually transmitted diseases. Albertans were better informed about reproductive health and disease and doctors were better trained and supported.

Dr. Gokiart succinctly states the ethos of a remarkable group of people that worked passionately on behalf of women and children for all those years.

“It was advocacy and teaching rather than pointing fingers. We were the only ones doing it and the AMA took it on and did a very good job.

“Doctors will continue to be professional and continue to search for the truth. This is what we did in the past and this is what we will continue to do.

“Sometimes it takes a long time to effect change. It comes through continuing education and it has to fit into someone’s reserve of knowledge they have already obtained in medical school and in practice. We always go forward and revamp what we did in the past.”

¹⁷ Letter from the deputy minister, June 7, 1999.

¹⁸ Correspondence from McLennan Ross, Barristers & Solicitors, with the Alberta Medical Association, September 16, 2001.

CHAPTER THREE

Making Childbirth Safe for Women: The Maternal Welfare Committees

There was a time our grandmothers remember when pregnancy could trigger alarm and worse for the woman awaiting the birth of her baby. Any complication – and there might be many – could lead to illness and death for the mother and the child. To the physician who saw too many deaths that could have been prevented, to the loved ones who watched in vain, the thoughts were obvious – there must be solutions.

In the early 1950s, the Alberta government was also concerned. Its respected Minister of Health, Dr. Donovan Ross, acted on the urgings of the equally regarded professor of obstetrics at the University of Alberta, Dr. J. Ross Vant, who wanted funding for a perinatal program spearheaded by the Alberta Medical Association (AMA). The AMA would elect a committee to “study the problems in this area of health care delivery and pose some solutions.”¹⁹

In 1954, the National Health Grants Program approved the Alberta government’s grant application and the AMA’s Perinatal Program went to work. Its Board of Directors appointed the chairs and members of the two crucial committees: the Committee on Perinatal Mortality and the Committee on Maternal Welfare.

Each was assigned specific duties that ultimately overlapped or became redundant – but not for another 30 years when, in 1984, the two committees amalgamated and met together as one: the Committee on Reproductive Care (RCC).

“With the advances in medicine and the changes in society’s views on childbirth it became apparent that these two committees could no longer fulfill their roles in the 1980s without overlapping their work. Both committees, after examining this question, jointly proposed to the board of the AMA that the two committees be combined into one committee on reproductive care. This would allow the issues to be viewed from both the mothers’ and babies’ perspectives simultaneously.”²⁰

When the two committees began, however, their mandates were decisive, distinct and well-suited to the times.

The Committee on Perinatal Mortality discussed and classified all perinatal deaths in the province. “From its examination of cases, the Committee made recommendations, through the Board of the AMA, on standards of medical practice in Alberta.”²¹

The Committee on Maternal Welfare focused exclusively on the health and welfare of the mother giving birth. “This included all maternal deaths, cesarean section

¹⁹ Please see *Reproductive Care Committee of the Alberta Medical Association: Future Directions and Funding*. Unpublished paper, 1986.

²⁰ Ibid

²¹ Ibid

rates, abortion statistics, home births and any other aspect of childbearing that could affect outcome in terms of maternal health.”²²

During the 30 years that the two committees operated so effectively and efficiently, one person was largely responsible: Rachel Tasker. The AMA’s Perinatal Program was unique in Canada for her dedication, tenacity and longevity in the job. Indeed, Miss Tasker’s very name suggests the truth; she was a taskmaster.

Even before the Perinatal Program was successfully launched by the AMA, Alberta doctors had established themselves as thoroughly dedicated to the welfare of mothers and babies by forming the province’s first Committee on Maternal Welfare. Its chair was the same Dr. J. Ross Vant who, in 1936, submitted the committee’s first report to the *Alberta Medical Bulletin*.

Dr. Vant noted that “this report, given without rancour, is indefinite,” basically due to the lack of available information. He is very specific, however, on these conclusions.

1. “Women must be taught to consult the physician early and regularly in order to receive the initial and continuing prenatal care which will not only decrease the incidence of vomiting and toxæmia, but result in the patients being more conscious of symptoms which should be reported to the doctor.”
2. “Major ‘Obstetrical Procedures,’ unless emergent, should only be performed in hospitals adequately equipped to deal with the sepsis which may follow.”
3. “The present questionnaire form does not result in either adequate or definite information to enable the Committee to assess the data satisfactorily; consequently a new form has been assembled. It is more nearly complete than the previous one, but may rouse the rancour of the physician by the number of queries. It is hoped, however, that the doctors on whom falls the onus of filling out the forms will do so as completely as possible. For that information, this Committee will be grateful.”

Dr. Vant’s very first report encapsulates the dedication, direction, discretion as well as frustration of committee members whose mission was to make childbirth as safe as humanly and medically possible. Dr. Vant’s pleas were not ignored, however, and the following year, thanks to the doctors’ forms, the committee’s report was able to describe in more detail the reasons why a pregnant woman died. From this came their analysis and “pertinent comments.”

One of the most worrisome “pertinent comments” from 1937 to 1939 is this: “70% of all deaths following abortion are those self-induced.” In 1940 the committee wrote: “The incidence of self-induced abortion is alarming.”

Clearly the committee and its chair were deeply concerned and looking for ways to stem such a tragic outcome to a woman’s pregnancy.

They also believed passionately that maternal deaths within the human “race” were still far too frequent. “It is felt that a review of local maternal deaths . . . would

²² Ibid

be valuable not only to assess causes but to determine future courses of treatment. The lives of our mothers are the nuclei of our race, they must be safeguarded. And the task is never-ending.”²³

That’s one reason why the committee continued to thank the doctors for taking the time and effort to finish the detailed forms.

“Your committee realizes that completing the forms is a tedious and tiresome task especially when it is done months after the maternal death has occurred. Your co-operation throughout the past years is appreciated and its continuance is earnestly requested.”²⁴

Filling out the “tedious” forms could be quite cathartic for those physicians who had lost patients. The prodding by Dr. Vant slowly began to pay off. Certain trends emerged as committee members researched, reviewed and then recommended changes. Many of those are still relevant today.

“Postpartum haemorrhage still remains the greatest single cause of maternal death. The use of Vitamin K during the last month of pregnancy and the intravenous use of Ergonovine during the third stage of labour may well be tried more generally,” wrote Dr. Vant in his 1943 report for the *Alberta Medical Bulletin*.²⁵

During this time, World War II was raging around the globe and Dr. Vant felt passionately that even as soldiers died on the battlefield, mothers who died in childbirth must be remembered too.

“Toxaemia and Eclampsia are probably due as much to the patient’s indifference as to the busy doctor’s neglect of adequate antepartum care. A dead mother is, however, a greater loss to the nation than a dead soldier. Not only does the family suffer the loss of a guiding hand, but the nest for future offspring is permanently destroyed.”²⁶

Dr. Vant and the committee thanked those doctors on the home front who were doing their best in providing care, and by 1944 the number of maternal deaths was dropping.

Still, Dr. Vant was always vigilant and ready to press new issues.

“Too little attention is given to the mother who has just delivered. She should be watched for at least one hour postpartum and any bleeding should be controlled by fundal massage and administration of an Ergonovine compound. Failure to take these precautions caused six maternal deaths during the preceding year.”

“Haemorrhage was the commonest cause of maternal deaths during the past year,” he wrote in the committee’s 1945 report. Then he provided very direct solutions.

²³ J. Ross Vant, *Alberta Medical Bulletin*, 1950, p. 17.

²⁴ Ibid

²⁵ p. 44

²⁶ Ibid

“Where the patient is at term, the conservation of blood loss is again paramount. The doctor is so often inclined to minimize blood loss, and to prevent this, the amount lost should, if possible, be measured. Any blood loss in excess of 300 ccs should be replenished as soon as possible.

“The diagnosis of pulmonary embolus is often made too quickly and superficially. Avoidance of blood loss, earlier movement of the extremities and even early rising may minimize this occurrence.”

Dr. Vant’s prescription is just as pertinent 60 years later. Many a mother remembers the hours just after she had given birth when the nurse patiently urged her to rise and walk, even as sleep so blissfully beckoned.

By 1949, Dr. Vant was commending the province’s doctors for a job well done. Of the 24,955 births that year, 24 mothers had died. This was a marked improvement from the high rate of 1937, when 61 mothers died out of 16,237 births. The meetings, the digging for statistics, and the subsequent prodding of physicians were already paying off.

But no one rested on his or her laurels. Dr. Vant and the committee saw more room for improvement. At the time, the committee didn’t imagine that women doctors would attend patients, even though in 1949 women were slowly being admitted to, and graduating from, the medical schools.

“The pregnant woman must be taught to faithfully attend the doctor for prenatal care. Routine weight, blood pressure and urine examination together with the necessary abdominal examination always reveal the trend toward toxæmia and disproportion. If the need for consultation arises the attending physician can then avail himself (sic) of that privilege. Any operative obstetrics should be referred to a centre where competent men (sic) and facilities are available. The patient’s welfare must be the primary concern of the attending physician.”²⁷

That advice is as sound as ever. What exists no longer is a medical culture so thoroughly dominated by a male hierarchy. Over the course of the committee’s tenure, that culture would change as women from all facets of the medical world took their turns as leaders.

The committee reports grew much broader and served as useful guides to physicians and other medical staff. Of 27,991 births in 1951, 22 women died after complications related to pregnancy. The new chair, Dr. A.H. MacLennan, did not mince words.

“Most of these deaths were preventable. In some cases the patient neglected to seek medical advice or carry out the prescribed routine of treatment. In a few cases, the physician appeared to have erred in his judgment of the seriousness of the patient’s condition or in his method of treatment.”²⁸

²⁷ Report of the Committee on Maternal Welfare, 1949.

²⁸ Report of the Committee on Maternal Welfare, 1951.

Dr. Maclennan, like his predecessor, Dr. Vant, pointed again to the perils of hemorrhage, shock and the “toxemias” in women who are pregnant. He strongly suggested that these topics be examined not only at the annual meeting of physicians but at related district discussions throughout the province.

That year’s report also included the observations of the committee’s oldest member who said: “I am impressed at this meeting with the tremendous progress made in the art and science of obstetrics in Alberta during the past forty years.” To which Dr. Maclennan astutely added: “That is certainly true. Our primary responsibility is still the welfare of the mother and baby and let no progress blind us to that aim.”²⁹

While maternal deaths had declined over the life of the committee, perennial problems remained: abortion as a means of birth control; and ignorance, indifference or downright denial by the mother. The outcome could be tragic – hemorrhage, toxemia and death.

“Some of the deaths must be considered preventable, but in almost every case the opportunity to provide adequate care was denied the attending physician by the poor co-operation of the patient in some instances, and by the catastrophic nature of the circumstances in others.”³⁰

There were other challenges about which the committee members were deeply concerned – the death of babies. In his 1953 report, Dr. Maclennan wrote:

“It has been suggested that a committee on Infant Welfare be set up. Your committee recommends that this be incorporated in the Committee on Maternal Welfare and to be augmented by one obstetrician and two paediatricians as members. Your committee as well recommends that if dominion and provincial funds are available, that steps be taken to secure a grant from these funds to augment the work of the committee.”³¹

This proposal was ultimately successful and the Committee on Perinatal Mortality was established in 1954. Over the next 30 years, the work of the two committees would ultimately overlap. In 1984 they would merge into the Committee on Reproductive Care.

Throughout its tenure, the Committee on Maternal Welfare was profoundly concerned about alleviating all preventable deaths of pregnant women. For this the members needed pertinent information, which was not always readily available. Dr. Ronald H. Horner, the committee’s secretary and chair, described the challenge forcefully in his 1957 report. One can almost feel the heat rising from the lines.

“It has been the policy that the Department of Vital Statistics notify the Committee Secretary, Dr. R.H. Horner, of any death certificate in which a pregnancy is mentioned; but this has not been accurately followed through. Only by July, 1958, and

²⁹ Ibid

³⁰ Report of the Committee on Maternal Welfare, 1954.

³¹ Report of the Committee on Maternal Welfare, 1953.

as a result of much correspondence has this obstacle been overcome – and we hope that in the future, the Committee will be kept advised of all maternal deaths.”³²

Dr. Horner also repeated the real purpose of the information and the non-judgmental need to get to the facts behind any fatality. This spirit of cooperation over confrontation, and the ultimate search for truth, was at the very heart and soul of the committee’s work. Indeed, the culture of the Committee on Reproductive Care was established generations before its inception by these earlier doctors whose primary goal was patient health.

“The Committee as it now stands is largely for statistical reasons as well as discussion and summation of the facts, and in no way is meant to be critical of the patient, the doctor or the hospital. No liaison between Committee and doctor is involved other than for obtaining all pertinent data – and after discussion and assessment of the case, no further correspondence takes place. We endeavor to honestly assess the case, determine preventability or not, and in order to do this, we must have all known details.”³³

Two years later, Dr. Horner thanked the many contributing physicians for their crucial form-filling, but was equally quick to chide one or two each year, calling them “a hard core of physicians from whom it seems almost impossible to obtain any medical report.”³⁴

The prodding was working. By 1961 Dr. Horner noted that in Alberta all physicians were cooperating with the detailed work of the committee in obtaining “any pertinent information” regarding a maternal death. This wasn’t the case across the country, where investigators were often assigned to maternal deaths. As a member of the newly revived National Committee on Maternal Welfare, the Alberta committee was often ahead of its peers in its approach and its crucial statistics.

“It is apparent, after attending the (Canadian Medical Association’s National Maternal Welfare Committee) meeting in November, 1961, that Alberta has as good a record as any province in Canada; in fact, better than many. It is also interesting to note that Alberta was one of the first provinces to institute a Maternal Mortality Committee and that only in the last few years have some of the other provinces become interested in this field of maternal welfare.”³⁵

To ensure that everyone was reading the right page and understanding exactly what constituted a maternal death, the committee decided to “briefly outline some terminology and definitions.” The following is from the Committee on Maternal Welfare Annual Report for 1960.³⁶

Maternal Death: A maternal death is the death of any woman dying of any cause whatsoever while pregnant or within 90 days of the termination of the

³² Annual Report of the Committee on the Study of Maternal Deaths for Year 1957.

³³ Ibid

³⁴ Committee on Maternal Welfare Annual Report, 1959.

³⁵ Committee on Maternal Welfare Annual Report, 1961, p. 14.

³⁶ Pages 4–5.

pregnancy, irrespective of the duration of the pregnancy at the time of the termination or the method by which it was terminated.

A. Direct Obstetric Cause of Death: A death resulting from complications of the pregnancy itself, from the intervention elected or required by the pregnancy, or resulting from the chain of events initiated by the complication or the intervention.

1. Hemorrhage
2. Toxemia
3. Infection
4. Vascular Accidents (such as Embolism, Amniotic Fluid Embolism)
5. Anesthesia
6. Other (such as Molar Pregnancy and Transfusion Hemolysis)
7. Undetermined

B. Indirect Obstetric Cause of Death: A death resulting from disease before or developing during pregnancy (not a direct effect of the pregnancy) which was obviously aggravated by the physiological effects of the pregnancy and caused or contributed to the death.

1. Cardiac Disease
2. Vascular Disease (such as Hypertensive Vascular Disease and Vascular Embolism)
3. Reproductive Tract Disease (such as Uterine and Adnexal Tumors)
4. Urinary Tract Disease
5. Hepatic Disease
6. Pulmonary Disease
7. Metabolic Disease (such as Diabetes)
8. Other (such as Appendicitis and Peritonitis of non-puerperal origin)
9. Undetermined

C. Non-Related Cause of Death: A death occurring during pregnancy or within 90 days of its termination from causes not related to pregnancy, nor to its complications or management.

1. Communicable and Infectious Disease
2. Blood Dyscrasias
3. Malignancy
4. Suicide
5. Murder
6. Accidental
7. Undetermined
8. Other

Once again, this rigorous dedication to detail bore fruit in direct benefit to perinatal health. Within the decade from 1950 to 1960, the number of maternal deaths dropped by nearly 60 percent, from 1.0 per 1,000 births in 1950 to 0.41 per 1,000 in 1960. While Dr. Horner felt “the committee should not be unhappy with” those rates,

he wanted them to be lower still. “Nonetheless, we should constantly strive to improve and decrease our maternal mortality statistics.”³⁷

That they did. Armed with better information, better technologies and more effective transportation, doctors and nurses saw the number of maternal deaths drop throughout the 1970s from 1.2 direct deaths per 10,000 births in 1970 to 0.5 direct deaths per 10,000 in 1980.

Committee members were determined to explain all deaths and refused to ignore any role a patient or doctor might have played in a tragic demise. Many of the deaths were unavoidable, but certainly not all. While examining the summaries of maternal deaths over the many years, the vigilance of the doctors on the committee is commendable. No names are mentioned in the reports, but whether a death was unavoidable or not, the truth was plainly stated, in red ink.

“Massive pulmonary embolus: Recent delivery – caesarian.” Typed immediately beside this statement, in red, is one word: “Unavoidable.”

“Cardiac arrest: Postpartum hemorrhage – cause unknown.” Again in red, the word “Unavoidable.”

“Pulmonary collapse: Associated focal hepatic necrosis.” And “Unavoidable.”

Not all maternal deaths were unpreventable. Committee members, after careful consideration, did discover practices that led to a patient’s demise. It was these kinds of causes that they never wanted repeated in a mother’s care.

“Postpartum hemorrhage due to ruptured vein in broad ligament,” was one direct cause of a maternal death. Then, in red, are these three words: “Avoidable – physician error.”

A direct cause of death is listed as: “Cardiac arrest with associated postpartum bleeding due to lacerations of cervix and vagina; possible laceration of the uterus.” This is followed by: “Avoidable – physician error.”

“Acute yellow atrophy of liver; Serum hepatitis due to fibrinogen administration eight weeks prior to death.” Then: “Avoidable – physician error.”

Such cases, although rare, were extraordinarily painful for families, the attending doctor, and the committee members investigating them. Yet there is no evidence anywhere that the committee ever shied away from hard truths.

Although always sympathetic, the committee could become exasperated by the negligence of the patients themselves. Too often this led to oversights that cost the lives of both mothers and babies. The committee constantly stressed the importance of visits to the doctor during a patient’s pregnancy and afterward. The reports are peppered with too many entries such as: “Acute puerperal endometritis; Septicemia; Postpartum hemorrhage; Anemia; Associated Pneumonia.” And then the verdict in red: “Avoidable – patient error.”

³⁷ Committee on Maternal Welfare Annual Report, 1963.

For much of its tenure, the committee was absorbed in the cause and prevention of maternal deaths. As the mortality rate subsided, other crucial issues climbed to the forefront. During the 1970s and 1980s, the committee dealt with some of the most controversial issues of the day: therapeutic abortion; sexually transmitted diseases; Fetal Alcohol Syndrome; sex education; teenage sexuality; and home births.

The Committee on Maternal Welfare, chaired by Dr. Leonard G. Evenson, presented its last stand-alone report to the AMA's 79th annual general meeting on September 27 and 28, 1984. The summary succinctly stated the year's activities, along with the committee's demise.

"The Committee supports the consolidation of the Committee on Maternal Welfare and the Perinatal Committee into one Committee on Reproductive Care."

With that simple statement, the Committee on Maternal Welfare became a creator of the AMA's next success story – the Committee on Reproductive Care.

CHAPTER FOUR

Making Childbirth Safe for Babies: The Perinatal Mortality Committees

The maternal death rate was well on its way to dropping in the early 1950s, but mortality among the newborn was still far too common. Dr. J. Ross Vant, the man behind the formation and early success of the Committee on Maternal Welfare, was disturbed at the high infant death rate and focused his sights on solutions he understood from experience.

“The Perinatal Program was initiated by Ross Vant, a fine character who based it on the work of Sir Dugald Baird of Aberdeen, Scotland. They looked at reproductive patterns and discovered that the less privileged had more birth problems. They examined such things as nutrition and the availability of medical care,” recalls Dr. John J. Boyd, a former committee chair.

As a member of the Alberta Medical Association (AMA) and a professor of obstetrics at the University of Alberta, Dr. Vant discussed the perinatal mortality problems with his colleagues, including Dr. William Bramley-Moore and a certain Rachel Tasker.

Dr. Vant contacted Dr. Donovan Ross, then the Alberta Minister of Health, and proposed the Perinatal Program. As an elected committee of the AMA, the Alberta Committee on Perinatal Mortality would support the program and funding was sought from the National Health Grants Program with approval from the Alberta government.

It worked. The Perinatal Program received funding in the fall of 1954. The committee’s initial functions were carefully detailed:³⁸

1. “To provide a study of infant deaths during the first 14 days of life, nearly all of them occurring in hospitals.
2. “Through cooperation between the University of Alberta, the College of Physicians and Surgeons, and the Associated Hospitals of Alberta, to initiate educational and other steps to improve the situation.
3. “The local committee (members) who have been discussing this, see it as a continuing program, rather than as a research project.
4. “It is seen as supplementary to, and a continuation of, an investigation which has been carried on for years into the causes of maternal deaths.”

The objectives of the committee mainly involved monitoring the way in which obstetrics was practised in the province, and the collection of data. Dr. Tom+ Nelson, who had worked with Professor Baird in the Aberdeen, Scotland, studies, advised the committee on developing the “Cause of Death Classification.”

³⁸ Summary of the conclusions reached at their two interim meetings by the subcommittee discussing projects. Unpublished notes, 1959.

“The basic principal of this classification is that, to reduce perinatal mortality, one must go back to the first link in the chain which put the baby in a situation which resulted in its death.”³⁹

The committee’s tasks were daunting and its members and advisors approached Miss Tasker to become the coordinator of the newly-funded Perinatal Program. As a midwife, nurse and U of A faculty member in the Advanced Practical Obstetrics Program, Miss Tasker was a logical choice. Indeed, she almost seemed born to do the job.

“Rachel Tasker was absolutely passionate and single-minded over this program,” says Pemme Cunliffe who succeeded Miss Tasker as the program coordinator – 30 years later, in 1984. (Ms Cunliffe remained coordinator until 1991 and is now a lawyer.) “This was her life; she developed the program. She was almost a tyrant about it; she followed up and made sure that every one of these babies was reported and followed up; she visited all the hospitals in Alberta and made sure they understood the program.”

Ms Cunliffe points out that it was Miss Tasker who continued to build the crucial relationships with the province. When the Federal Government eliminated its health grants program, the Alberta government stepped in.

“She convinced the government that the Perinatal Program was a good thing to fund. I don’t think the program would have gotten up and running without her or someone like her,” adds Ms Cunliffe.

Dr. Philip C. Etches, a committee member and later chair of the Committee on Reproductive Care (RCC), remembers Miss Tasker as “a one-lady show. She was very dedicated and regarded with a certain amount of awe. She got the job done.”

Always, she did it with a quick mind and firm hand. Dr. Boyd who chaired the Committee on Perinatal Mortality in the 1970s, remembers the meticulous notes that Miss Tasker kept of every perinatal and maternal death in the province.

“If you were the physician involved, you had to fill in the form on everything that happened. Rachel Tasker rode herd on these people, getting them to send reports.”

Miss Tasker would not be ignored. Physicians who failed or simply forgot to finish the forms were not in for a treat. Tasker would head to the hospital and physically find the recalcitrant doctor.

“She was a pretty sharp-tongued lady who stood no nonsense. Rachel Tasker was a good old-fashioned ward sister, cracking her whip and getting everybody in order,” says Dr. Boyd good-naturedly. “She gave her life to this business, night and day, as well as weekends. She produced a report every year, on time, before there were computers.”

Dr. Boyd would chat with Miss Tasker at least once a week. He invited her to the family home for dinner, but she never came. Work was her passion and her life, even on holidays.

³⁹ Ibid

“She was from St. Thomas’ Hospital in London, which was Florence Nightingale’s hospital and named after Sir Thomas Becket. Tasker was a single lady, and on Christmas day, there she was with her office light on. I threw snowballs at her office, but she didn’t come to the window. She was a very private lady who gave her life to the committee.”

The perinatal and maternal reports that Miss Tasker developed and completed were, in his view, “second to none. To get someone like Rachel Tasker, one person doing it and covering the whole area, is really quite remarkable.”

It seems that Miss Tasker returned the admiration in her quiet way. Aside from her total dedication to her work, she also kept pictures on her wall of the various committee chairs. It was a group that won her respect, if not always her compliance.

Dr. Reginald S. Sauve, a former committee member, remembers Miss Tasker having “quite the debates” with an equally determined and opinionated doctor who headed up a hospital neonatal unit. This only underscored her reputation for “running a really tight ship.”

Dr. Charlene M.T. Robertson, who worked with the perinatal mortality committee and its successor, described Miss Tasker as a take-charge, no-nonsense British nurse. She remembers her depth, dedication and determination, as well as her recommendations, which were strong, relevant and often ahead of their time.

“Rachel Tasker had a deep voice and was pleasant, but what she said, she meant,” says Dr. Robertson, who recalls Dr. Boyd always mentioning Miss Tasker’s work and the long list of statistics she had compiled.

Dr. Robertson also remembers how Miss Tasker pondered and studied her statistics time and again for clues to the causes of inexplicable deaths. She noticed more deaths occurring at night and on weekends and believed those might be cut if anesthesiologists were continuously available.

“She advocated for that long before anyone else,” adds Dr. Robertson. “Her statements made you think we could improve things.”

Developing files and compiling statistics were crucial to the perinatal mortality committee as it worked to lower the perinatal death rate. Over the years, Miss Tasker’s meticulous manner moved everyone involved. Most of all, her thorough research told the story, revealing the broader truths across a broad range of individual cases.

“She did what any good researcher does and didn’t make up stories. She told us what the data was telling her. We felt we should act on it yesterday to make things better,” recalls Dr. Robertson, who is also a researcher. “It’s very hard work.

“She had a whole cohort – the whole province. She had all the hospitals in the province eating out of her hand and giving her data. She wasn’t just saying ‘I have a sample.’ She had the whole province.”

Miss Tasker’s data were compiled from all possible sources related to infant mortality in the province. There was no sampling when it came to her research. It was

supersized all the way. When compiled correctly, this information had great power, and she knew how and when to use it.

“It was a combination of the strength of her data and her personality,” says Dr. Robertson. “She had an excellent sense for numbers and knew how to make them meaningful. She had a medical sense too. Then, she went for change. Rachel Tasker tried really hard to make a difference.” Dr. Robertson adds with emotion: “It was very hard for her to give up the committee.”

In 1954, the National Health Grants Program first awarded her the funds to administer the Perinatal Program. At the time she was on faculty at the University of Alberta, where she would teach for four months of each year and spend the remaining eight months on the perinatal project.

“Because of this arrangement, the University agreed to administer the money as a Trust Fund in Miss Tasker’s name. Her salary was paid equally by the grant and the University until 1957, when she resigned from her teaching post in order to devote all her time to the Perinatal Program. The University supplied office space until 1961.”⁴⁰

The very first meeting of the Alberta Committee on Perinatal Mortality was held in February 1954. “The purpose of this Committee is to study the deaths occurring in Alberta at and around the time of birth. The Committee felt that their main objective should be to stimulate interest in the large group of babies who are either born dead or die within the first week of life and it was decided that the study should be limited initially to this group.”⁴¹

Dr. Lloyd. C. Grisdale was the committee’s first chair, and his report explained the need to compile a questionnaire, the Alberta Perinatal Death form. Provincial physicians were thanked for supporting the committee’s work, with Dr. Grisdale’s report noting: “We have only had two doctors who refused to cooperate.”

The committee met every month or so to “frankly” discuss and attempt to determine “why the child died and what could be done to prevent another death occurring in similar circumstances.”⁴²

In 1954, 33,588 babies were delivered in Alberta. Of that number, 876 died and were classified as perinatal mortalities – stillbirths and infant deaths. A year later, of 35,323 deliveries, 804 were classified as perinatal deaths. Within one year, the number of deaths dropped from 25.6 deaths per 1,000 births to 22.7.

Dr. Grisdale’s committee was delighted: “This figure is highly significant and may be due to the increased interest displayed throughout the province on this subject.”⁴³

The committee members were exceptionally concerned about the higher number of babies dying in the rural areas, where “transportation difficulties” could present a

⁴⁰ From *Reproductive Care Committee of the Alberta Medical Association: Future Direction and Funding*, unpublished paper, 1986, p. 2.

⁴¹ Alberta Committee on Perinatal Mortality summary for 1954, presented at the annual general meeting of the Alberta Medical Association.

⁴² Ibid

⁴³ Annual report for 1955.

significant risk. There was also a “strong feeling that the premature mortality rate for Alberta” was high.

Finally, the committee presented its first chart on “Preventability Factors in Alberta Perinatal Mortality.”⁴⁴

Preventable	136
Non-Preventable	407
Unclassifiable	261
1. Inadequate prenatal care	34
2. Family at fault	30
3. Physician, error in judgment; Physician, error in technic (sic)	109
4. Intercurrent disease	22
5. Unavoidable	356
6. Unclassifiable	253

Over the years, committee members have been concerned about the definitions used for stillbirths and infant deaths. In a comparative study of Alberta and Winnipeg perinatal rates, the Alberta perinatal mortality committee noted that: “The apparently favorable comparison may not be valid because of the wider weight range in the Winnipeg Study.” The Alberta committee successfully urged the provincial Department of Vital Statistics to develop definitions that could be compared with other studies across the country and around the world.

In 1959, the provincial *Vital Statistics Act* did just that. A birth was officially defined to mean “the complete expulsion or extraction from the mother, irrespective of the duration of the pregnancy, of a fetus in which, after expulsion or extraction, there is breathing, beating of the heart, pulsation of the umbilical cord or unmistakable movement of the voluntary muscle, whether or not the umbilical cord has been cut or the placenta attached.”

A stillbirth “means the complete expulsion or the extraction from the mother after at least twenty-four weeks’ pregnancy, or after attaining a weight of seven hundred and fifty grams or more, of a fetus in which, after the expulsion or extraction, there is no breathing, beating of the heart, pulsation of the umbilical cord or unmistakable movement of voluntary muscle.”⁴⁵

Within two years, the committee would recommend that the *Vital Statistics Act* for 1963 change the definition of a stillbirth to “at least twenty weeks’ pregnancy or after attaining a weight of 500 grams or more”.

Exact definitions would become more sophisticated over the course of the committee’s tenure, and that of its successor, the RCC. Innovations in medical science and technology meant a baby could be born and live at even less than 500 grams. The consequences for provincial mortality rates could be quite controversial.

⁴⁴ See also Dr. R. J. Ostolosky, “Avoidability in Perinatal Mortality,” *Alberta Medical Bulletin*, February 1962.

⁴⁵ Alberta Committee on Perinatal Mortality Progress Report for the Year 1958-59, pp. 2-3.

“The increased infant mortality rate in Canada in 1993 appears to be due to increased registration of infants weighing less than 500 grams as live births. Comparisons of infant mortality rates by place and time should be adjusted for the proportion of such live births, especially if the comparisons involve recent years.”⁴⁶

For doctors sitting on the perinatal mortality committee in the 1960s, the focus was on babies weighing less than 1,000 grams. “The survival rate for babies in this weight category is only about 4 percent in Alberta and this is close to the findings in other studies. The problems presented by these very premature infants are, in a general sense, different from those associated with more mature babies.”⁴⁷

The fact that discussions over the last 15 years have centred on the viability of babies weighing less than 500 grams shows the progress and the challenges that doctors face in the new era of innovation and medical science. Yet the heart of the matter remains the same – the baby’s survival and health.

That would be a central concern for the committee as medical science continued to create miracles as well as moral dilemmas for a society striving to challenge and sometimes cheat nature.

Another more pressing concern was funding for the Perinatal Program and the committee’s work.

Dr. Margaret M. Hutton, the first woman obstetrician and gynecologist in Edmonton, joined the Committee on Perinatal Mortality in 1960 and served as chair from 1963 to 1967. She was mortified that the grant to support the work was close to being withdrawn. In a letter dated February 25, 1966, to Dr. Rupert M. Clare, President of the Alberta Medical Association, Dr. Hutton deplored the Association’s decision to terminate the grant for the Perinatal Program.

“It seems ironic and unrealistic that the Alberta study which was the pioneer study in the world should be fading out just when other provincial studies are being launched.” (Emphasis hers.) She pointed out how widely the research and work of the Perinatal Program and the committee were cited around the country and, indeed, the world. Dr. Hutton also explained the committee’s crucial commitment to education: “It is the educational aspect of the review of perinatal deaths which is of fundamental value to the medical profession. This has been the most important objective of the perinatal mortality committee, and one which we would hope to see developed in the future for the protection of the profession and therefore ultimately for better patient care.”

She concluded with these prescient words: “With the increasing preoccupation of the public with the affairs of medical practice (and with the whole area of pregnancy, delivery and the newborn, making good copy for women’s magazines) it seems to be of greater, not less, importance that the medical profession should do all that it can to control and improve the quality of medical practice.”

⁴⁶ K.S. Joseph and M.S. Kramer, 1996. Recent trends in Canadian infant mortality rates: Effect of changes in registration of live newborns weighing less than 500 g(rams), *Canadian Medical Association Journal*, Vol. 155, Issue 8, pp. 1047-1052.

⁴⁷ Alberta Committee on Perinatal Mortality Progress Report for the Year 1961-62, p. 4.

Dr. Hutton's arguments were extremely persuasive. The work of the committee and the Perinatal Program was being recognized far beyond the province, with committee members presenting research findings to colleagues and conferences in California, Arizona and Florida, as well as in England and New Zealand. Requests for copies of their studies and papers came from major centres on every continent.⁴⁸

The funding, as with any non-profit program, would continue to be a challenge. Ultimately the province of Alberta provided support, along with the AMA.

Throughout the committee's tenure it would tackle such issues as the rise in numbers of cesarean sections and multiple births; premature births; the high risk fetus; prenatal care; fetal alcohol syndrome; neonatal intensive care units; transport of newborns; communications; electronic fetal monitoring in small hospitals.

"The development of the Intensive Care Unit and the Neonatal Care Unit in the 1970s were crucial to the drop in the perinatal mortality rate. The air ambulance system was another milestone," notes Red Deer physician, Dr. J. Robert Lampard, Director of the Alberta Medical Foundation.

The depth of research and breadth of statistics developed by the perinatal mortality committee were respected across the country. On May 5, 1970, Dr. Jean Webb of the Ontario Department of Health wrote to Rachel Tasker:⁴⁹

"The more I get into this and we are just beginning to scratch the surface, the more I appreciate the work that you have done over the years in developing the excellent system which you now have."

Dr. Robertson, who sat on the committee in the 1970s, remembers the collegiality and commitment of everyone to improve the caliber of care and feels the strongest part of the process was the individual peer review.

"It was a formidable thing to do to present data to a committee. The committee would address the issue and everybody got a chance to talk. The meetings were well structured and I don't ever remember disagreements during the time I was on it. It was stronger, certainly, than any other committee I've been on."

Former committee chair, Dr. Boyd, emphasizes that doctors were encouraged to tell the truth and that is exactly what happened. The aim wasn't to criticize but to discover precisely what occurred in order to improve the process.

"In obstetrics, none of us wanted any mother or baby to come to harm. It was our whole aim. Unfortunately it couldn't always be the case. Occasionally, the same doctor's name came up again but these were very rare occasions. There were a few doctors who refused, but most completely got involved," says Dr. Boyd.

At the time, the highest loss of babies occurred in small rural hospitals. The perinatal mortality committee for 1972-73, chaired by Dr. Raymond J. Ostolosky, was

⁴⁸ Alberta Committee on Perinatal Mortality, National Health Grants Program Project 608 -13 – 6; Requests for Reprints Received from the Following Places, nd.

⁴⁹ Dr. Jean Webb, Chief of the Maternal and Child Health Service, Special Health Services Branch, Public Health Division, Ontario Department of Health.

deeply concerned about rural at-risk patients and urged rural doctors to send mothers into the city hospitals where more help was available. Specifically:

A. The Committee recommends and reaffirms that the Alberta Medical Association ask the co-operation of physicians to ensure:

- (i) that where possible, at-risk newborns be anticipated and the mother transferred immediately for delivery where Neonatal Intensive Care Unit facilities are available to the newborn;
- (ii) that the referring physician contact the N.I.C.U. (or consultant paediatrician) immediately upon identification of an at-risk infant and before deterioration in its condition has occurred so that the transfer can be made in an orderly rather than emergency manner;
- (iii) that the minimal transport escort needed by an at-risk newborn is a graduate nurse with special preparation in at-risk newborn care;
- (iv) that where the condition of the newborn is such that it needs transport care by a physician, this should be arranged in consultation between the referring physician and the transport officer.

B. The Committee recommends that the Alberta Medical Association recommend to the appropriate authorities:

- (i) that air-carriers in Alberta provide instrument rating to aircraft used to transport patients, and
- (ii) that essential ambulance transport by land or air for at-risk mothers and newborns between hospitals be an integral part of the overall health care system with no additional cost to the patient.

The committee's recommendations were taken to heart and by the late 1970s most of the at-risk babies were being born in the large hospitals.

“So, the small hospitals had almost no deaths while the biggest hospitals had the large numbers. But the whole idea was to encourage cooperation and consultation between physicians working in small hospitals. They had the toughest jobs in this province. They're alone in a small place with limited facilities and limited people to help,” adds Dr. Boyd.

This was just one area where the Committee on Perinatal Mortality made an enormous difference in mothers' and babies' lives. It wasn't just in statistics that the committee and the province excelled; it was in compassion for the lives and tears that launched those studies. Committee member Dr. Sauve vividly recalls looking at the stories behind the numbers.

“When there had been a maternal death, you could tell when listening to the people talking with huge lumps in their throats. It would be looked at as preventable, even though it was not. You penetrated the depths of your soul.”

Whenever a baby had died, the obstetrician and pediatrician would have to write a report. Included were questions about how they would do things differently and whether there could have been another way.

“What would have been a better outcome for that family?” asks Dr. Sauve. “Every doctor and nurse was forced to reflect more than even they might have done.”

Yet the relationships with all concerned were very positive. Dr. Sauve says that the students and nurses were amazed with the committee and the program to review every death. They were reassured that these tragedies weren’t simply forgotten. The committee included young doctors in residency training, so that the next generation would learn from the experiences of the past.

“This committee was very meaningful for everybody. This is something they stuck by all these years,” adds Dr. Sauve. “There used to be just one doctor, one patient and that was the end of the story. Now it is much more open. There are so many safeguards built into the system that didn’t exist back then. And this Committee and the province helped to do that.”

The crucial peer reviews within the committee meetings included feedback from doctors, and now midwives, from across the province. Recommendations were made on how to improve care, but key to all the discussions was confidentiality.

“Committee members have been absolutely meticulous about maintaining confidentiality and it’s impressive they’ve carried on through these many years. The meetings themselves were a good sounding board with ideas to make perinatal care for mothers and newborns better. We got the most interested and knowledgeable people in the province to debate,” says Dr. Sauve.

The committee was instrumental in reviewing policies and guidelines, along with proposals for changes in care. All of that went into the end-of-year summary which many considered the standard for perinatal care in the province.

“Putting out the annual report was a big deal. Lots of researchers and teachers use that perinatal data. It is integral information that gets passed on to learners,” observed Dr. Sauve. “The committee was a key part of obstetrical history in the country.”

Dr. J. Guy Gokiart joined the Committee on Perinatal Mortality in the late 1970s and remained throughout most of the next decade as it merged into the RCC. He remembers that the issues were often hot-button, but the reaction to them by AMA doctors and staff was always supportive, knowledgeable and professional.

“Emotions arise when you don’t understand something or when you have a gut-reaction against it happening to you. It’s easier to lay out a format and plan and explain that this is what is happening. The committee members can come in as counsellors and provide a steady hand at the wheel. There’s a storm out there and we’re going to drive through it and help you out,” explains Dr. Gokiart.

The medical process was exceptionally professional with only a very small percentage of slipups; but, as with anything, one simple misjudgment could cascade into a monumental mistake. The stigma of finger-pointing could have obscured the

truth and prevented changes, but the AMA wasn't interested in recrimination. Its whole focus was getting the facts in order to make medical care in the province the very best. That's why the committee wasn't afraid to tackle sensitive issues.

Dr. Gokiert cautions that as we become more preoccupied with sophisticated diagnostics and monitors in the critical care of mothers and newborns, we must not forget the important part played by the committee's statistical survey. It was pivotal to providing quality care and perinatal medicine.

"It is the committee's experience that the quickest way of improving perinatal survival in a particular hospital or by a particular physician is to draw attention to the perinatal mortality rate as it relates to the particular perinatal problem. Where the Committee has intervened in such situations, improvements in perinatal care and perinatal survival appear to follow quite rapidly."

Realizing over the years that the issues and studies surrounding the care of the mother and the child couldn't and shouldn't be separated, the two distinct committees of the AMA decided to merge.

"There is a tendency for the interests of the two committees to overlap," noted Chair Dr. Richard G. Chaytors. In 1984, the Committee on Perinatal Mortality endorsed its amalgamation with the Committee on Maternal Welfare into the Committee on Reproductive Care.⁵⁰

On its 30th birthday, the perinatal mortality committee had moved on, as had its coordinator, Miss Tasker, who had retired with it. Over those years, the perinatal mortality rate had dropped dramatically. In 1954 it was 25.6 per 1,000 births; and in 1983 it was 6.2 (1,000 grams and over).

"As a testament to the success and importance of this program, look at the dramatic improvement in perinatal and maternal health over the past decades," says Grace Guyon.⁵¹

In 1955, 25 babies died out of every 1,000 births. By 1998, baby deaths had decreased to 5.2 out of every 1,000 births – a fivefold improvement.

[Please note the Alberta perinatal mortality rate and ratio: The rate is the perinatal deaths divided by (both the) livebirths plus stillbirths then times 1,000. The ratio is perinatal deaths divided by livebirths times 1,000.]

The passion and commitment of Alberta's doctors is told in the countless hours they gave of their energy and free time to the Committee on Perinatal Mortality. The beneficiaries were the mothers and babies not just of Alberta, but of Canada too. As the caliber of perinatal care rose, Alberta doctors and their medical colleagues were ready for the next level of challenge and success that would become the Committee on Reproductive Care.

⁵⁰ Perinatal committee summary for 1983.

⁵¹ From October 16, 2001 presentation to the Standing Policy Committee on Health and Community Living by Grace Guyon, Manager, Reproductive Health and Special Projects, AMA. Available at albertadoctors.org.

CHAPTER FIVE

From Criminal Abortion to Safe Childbirth: The Committees Wrestle with Tragedy and Fight for Change

There is no better time and place to have a baby than right now, and right here in Alberta. The immense changes in medical technology have paved the way for a smoother, safer ride for the pregnant mom. But in large measure, the foundation for that road was laid by the Alberta Medical Association (AMA) through the Committee on Reproductive Care (RCC), a visionary group of medical leaders.

The committee and its predecessors went far beyond conventions of the day to delve into the problems of pregnancy and birth, then present solutions. Committee members were thoughtful, thorough and persistent as they gathered information and statistics so that, ultimately, mothers and babies could survive and thrive.

“Here is a database that looks at what a difference that’s been made in terms of survival. I wouldn’t be surprised if it’s the most complete database in the world,” says former committee coordinator Pemme Cunliffe, a nurse and lawyer.

In 1960, the Committee on Maternal Welfare urged the medical profession to provide all pertinent information for each patient’s case: her current history, past history, obstetrical history, prenatal care, course of labor and complications, as well as postpartum progress.

“Every little detail concerning each case is essential, in order for the Committee to give a fair assessment,” wrote Dr. Ronald H. Horner, the committee chair.

Doctors needed to consider a number of points with each pregnant patient. In particular, doctors should provide:⁵²

1. Crucial consultation if there were major obstetrical complications.
2. Careful prenatal care.
3. Early recognition of potential complications.
4. Patient transfer to larger centres to treat major complications.
5. Adequate blood for transfusion in case of hemorrhage; this especially applied to outlying districts and smaller towns.
6. Extra attention to patients over 40, as well as those who had given birth, successfully, more than twice. There is dangerous potential of uterine rupture, postpartum hemorrhage, malpresentation and dystocia (abnormally difficult childbirth).
7. Great caution when using pitocin by intramuscular or intravenous drip. It is a lethal drug and should not be administered if there’s any question in the doctor’s mind.

⁵² This summary is from the Committee on Maternal Welfare Annual Report for 1960.

8. Correct diagnosis, knowing that the most common causes of postpartum bleeding are retained products of conception, uterine atonia, vaginal or cervical lacerations, or uterine rupture. (Uterine atonia, also known as flabby uterus, occurs when the uterus doesn't contract very well after birth, causing continued bleeding.)
9. Clear understanding that afibrinogenemia (a condition where the blood doesn't clot) is very rare. For this reason, fibrinogen should only be used when there is an accurate diagnosis. Fibrinogen is related to a high rate of infectious hepatitis and hepatic necrosis.
10. Immediate medical consultation when the patient might have other complications such as rheumatic heart disease, history of cardiac failure or aortic disease. This patient should probably deliver in a larger hospital with diagnostic and therapeutic facilities.

The records and data are a treasure trove for any researcher wanting to know what conditions were like 50 years ago.

Up to the 1960s, women didn't have the ability to control their reproductive cycles the way they do now. But in that decade, oral contraceptives and other forms of contraception became more prevalent. This helped to lower the tragic consequences of unwanted births and backroom abortions. In the 1970s medical innovations made childbirth safer. With better monitoring, the 1980s brought back "natural" childbirths with limited or no medication. Yet the number of cesarean sections also rose. By the late 1980s and early 1990s, there was a move to try to decrease the cesarean rate.

Over the past decade, however, cesarean sections have increased again, as have the number of older mothers giving birth. Some women believe they have the ability and right to decide when they become pregnant and what time they give birth. Today there are two streams that run parallel and only connect through a safe outcome.

"There's the natural childbirth lobby and there are those women who want to control everything, have the drugs and the C-section. They want the way that is least inconvenient to them," says Ms Cunliffe.

These social trends have been encouraged by innovative medical technologies. Neonatal units were introduced in the 1970s, and the study of perinatology and neonatology brought increased insights into improving care for mothers and babies.

Doctors have striven to do their best, as have their other colleagues in health. Medical innovations and sophisticated information have enhanced the work of those on the medical front lines. Instant communications can successfully call on expertise a block or a continent away. Efficient transportation, including airlifts, can whisk patients at risk to high-tech medical attention.

Fifty years ago a patient in peril had little of today's medical amenities. If she lived in the country, far from the city hospital, she had to rely on luck and speed, hoping she could reach her doctor in time.

Today, researching and reading about the number of women who died is a shock, especially when those deaths occurred after an abortion. In 1937, 17 women died

through self-induced abortions. This sad story was retold countless times into the 1950s and beyond. The tragic accounts of these women echo down through the years, crying out with agony from the early documents of the AMA committees.

A 24-year-old woman died after attempting an abortion with soapsuds. Another woman, aged 31, was found dead with soap and water in her vagina. Her uterus contained only a small piece of placenta.

A 22-year-old woman who had been pregnant for 23 weeks arrived at hospital with a high fever and in active labor. Within three hours she had a “spontaneous delivery by breech of dead fetus.” Her “condition deteriorated in spite of transfusions, etc.” and 30 hours later she died from “peritonitis and toxemia.” The doctors “suspected interference prior to admission,” which the Committee on Maternal Welfare duly noted with their comment: “Presumably a criminal abortion.”

Another tragic case involved a 26-year-old woman who became very ill and was admitted to hospital. She fell into a coma and within two hours had died.

The cause of death was “sepsis from an attempt at criminal abortion.” Yet an autopsy revealed that the poor soul was not pregnant. The Committee on Maternal Welfare, under chair Dr. A. H. Maclennan, was, quite literally, saddened beyond words:

“The case of the young woman who lost her life through thinking herself to be pregnant is included but your committee found itself unable to make any pertinent comment.” Instead, the committee referred to the “catastrophic nature of the circumstances” of this tragic case and others where criminal abortion led to death.

As noted in Chapter Two, a 1987 report calling for universal sex education in Alberta said: “We have given ignorance a fair trial and we are paying dearly.” Too many Alberta women paid with their lives.

By 1970, the whole discussion around therapeutic abortions had touched every facet of medical and moral debate. The Committee on Maternal Welfare was integrally involved in the amendments to the Criminal Code with respect to therapeutic abortions.

The committee’s executive secretary, Rachel Tasker, pointed this out in a letter dated May 14, 1970, that she wrote to Dr. Jean Webb, Chief of Maternal and Child Health Services within the province of Ontario’s Department of Health.

“It is now my job to keep account of the therapeutic abortions done in Alberta and analyze them. I do not know what will come of this but it is quite interesting.”

As ever, Miss Tasker took her “read-between-the-lines” approach on the very delicate topic of abortion. And indeed it was interesting. The committees’ members over the years managed to handle a potentially explosive topic with their usual diligence, depth and diplomacy.

They always worked fastidiously to try to save pregnant patients from dying needlessly. The tragedies of girls and women mortally succumbing to self-induced and criminal abortions dropped dramatically. “There have been no maternal deaths from

spontaneous or illegal abortions since 1972,” noted the committee’s annual report for 1975.⁵³

Many times, the Committee on Maternal Welfare had to walk the narrow tightrope between moral indignation and social transformation. “The committee stresses that attitudes in society are changing; with increasing population and the switch from rural to urban living, society would like to avoid unwanted children. The AMA would like to avoid being drawn into the controversy as to whether or not therapeutic abortion should be available ‘on demand’ but rather try to direct the energies of the pro- and anti-groups to tackle the fundamental problem of changing attitudes in society and to find some other solution to the unwanted pregnancy.”⁵⁴

Today, discussions about abortion can be just as fraught with emotion as they were 30 years ago, but girls and women are no longer dying in remote dingy rooms, or in hospitals where physicians are powerless to save them. Others share credit for this, but the key role of the AMA committees must surely rank as one of the greatest triumphs created by physicians in Alberta.

On July 21, 1969, Dr. Webb wrote to Miss Tasker for “up to date copies” of the perinatal studies that she was managing in order to develop an Ontario perinatal mortality study.

“I realize that this may take a bit of time, but we will appreciate having the most recent information from you, as I consider your study one of the best-administered programmes we have had in Canada.”

Miss Tasker took the opportunity to explain how the data were compiled and what type of study she believed would be most useful. The whole point was “the better care of mothers and babies.” That’s why morbidity studies were even more important than mortality ones, she believed.

“The mortality is probably not so important as the morbidity which may result from indifferent practices in maternity units and a low standard of obstetric and pediatric care of the mother and baby. Morbidity is much more difficult to get at but by attacking the mortality we hope that we are improving the morbidity.”

Miss Tasker outlined the sources of information for perinatal deaths; the Bureau of Vital Statistics, the hospitals and the pathologists. She also pointed out the challenges in getting the correct information and people to provide it. Establishing a personal relationship is key, she pointed out. Miss Tasker visited all the hospitals at the beginning of the Perinatal Program and developed crucial contacts.

“This is rather important because all physicians are more or less allergic to completing forms and having the right person put the form in front of him at a favourable moment can make a lot of difference to the way the job is done.”

The forms needed to be succinct and easy to complete, preferably with answers that said “yes” or “no.”

⁵³ Appendix I: Brief on the Operation of the Abortion Law, presented to the AMA, 1976.

⁵⁴ Ibid

“Ambiguous questions waste everyone’s time and bad handwriting wastes mine. One must aim at something which the physician can take out of the envelope, check off on the spot, and put into a return-addressed envelope, seal it and complete the job in a few seconds – otherwise he may never do it at all!” (Emphasis hers.)

Without the Internet and email, these tasks could be even more onerous than they seem today. Ultimately, the goal of Miss Tasker and all the others was to “abolish the form altogether” and use the computer. Developing charts, filling them in and interpreting the data was a dream that was ultimately realized.

“Incidentally, rounding up reports is a task that should be tackled with vigor and determination once initiated, or the sending out of reminders is a waste of time and postage. Once a request for a report has gone out, it must be battled through to the bitter end.”

And the end might be bitter for the doctor if Miss Tasker’s patience was tried. She would send more letters, make more calls, speak with more hospital heads and, finally, visit the hospital of the recalcitrant doctor.

“Usually one is busy getting the information sorted out when a rather shame-faced physician wanders in! When they realize that the committee really means to have every case reported, they do their best to co-operate. If I have to do a long drive after a report, I usually make a point of going on Sunday or a holiday and making sure that the delinquent realizes that I cannot spend my office time chasing round the province after his reports.”

Then Miss Tasker voiced the personal credo she brought to every part of her work: “The important thing is never to give up.”

Those words truly explain why she and the entire AMA program succeeded as they did, embracing obstacles as opportunities and refusing to recognize failure.

Indeed, that was the mantra of the program and the people whose commitment and passion made it work. The statistics and data that they collected were important and provide a record and pattern of care. But throughout the tenure of the AMA committees, it was people working together who made the real difference. That’s one fact that hasn’t changed in all those years since Miss Tasker said it best.

“I think that one has to accept the fact that, nice as it is to be able to tie things up into neat little statistical packages, the interaction which takes place is probably the most important factor in bringing down the perinatal death rate and improving the service to mothers and babies.”

CHAPTER SIX

Technology Versus Mother Nature: Counselling Sense in an Age of Science

The changes in childbirth over the last century have been dramatic. Complications during pregnancy lessened as medical science found solutions to common problems. Indeed, for many women, technology came to be the answer both to getting pregnant and to giving birth. Women who had been unable to conceive saw their modern sisters succeed through advanced reproductive technologies such as in vitro fertilization. These breakthroughs, however, also spawned a certain cavalier mentality, a belief that medicine could somehow bluff mother nature.

Dr. Leonard G. Evenson, an obstetric consultant to the Committee on Reproductive Care (RCC) and a former member, explains: “We feel we have science to overcome things. We feel that with ultrasound we should be able to predict a problem with, say, the umbilical cord. We can’t.”

The perinatal death rate would drop further if there were no umbilical cord accidents, blood clots or abruptions where the placenta separates from the wall of the uterus.

“They just come out of the blue,” Dr. Evenson says. “We can’t prevent them. There’s also congenital anomalies and we don’t know how to prevent those. There are things we have no control over and we can do nothing about. There are things we can.”

Indeed there are. It is directly due to medical advancements and committed care providers that the number of mothers and babies dying dropped dramatically over the last 70 years. This was what the RCC and its predecessors were all about.

“A healthy baby and a healthy mom. We never wavered on how we could achieve that,” says Dr. Carolyn A. Lane, the immediate past chair of the RCC.

Dr. J. Robert Lampard, Director of the Alberta Medical Foundation, notes that the major change in the last 50 years was the drop in the infant mortality rate. “The development of the ICU (intensive care unit) and NCU (neonatal care unit) was crucial. Before that there was just monitoring.” He also cites the role the air ambulance system has played in getting mothers and babies quickly to hospitals, an advance that was championed by the RCC.

Former committee member Dr. John J. Boyd recalls the optimism in the medical community that came with two breakthroughs – electronic fetal monitoring and improvements in ultrasound.

“We have had enormous progress with small babies. We can deliver babies without trauma and as gently as possible right into the incubator. There were many babies in the 1970s that died from the trauma of birth. That is virtually past now.”

The compassionate face of medicine has progressed alongside the obvious technical advances. This, too, was very much a focus for the RCC.

“Back when I started to practise, it was very uncommon to have dads involved in childbirth,” recalls Dr. Evenson. “They were in the bar or the waiting room. In the 1970s we saw the greater involvement of the father. Our patients were dictating to us what we do. That was a kind of adjustment for a lot of people to make. It’s a credit to the profession that they did that.”

Pemme Cunliffe, a lawyer, nurse and former coordinator of the RCC, noted that throughout its tenure, the committee members remained dedicated to improving the health of women and babies in Alberta.

“They did that in the environment that existed at the time but they also had a lot of influence on what the environment would be. Having fathers present at birth was an example. That was a huge change.”

It certainly was, in thought, practice and focus. Previously, when a woman went into labor, she was admitted to the hospital, gave birth and remained under care in the ward for a full two weeks – at least. No longer. Today, if a healthy mother remains a full two days in hospital, she will definitely be discharged, with her baby, the next day. The focus is getting mothers and babies home as soon as possible to an environment where there is, hopefully, support from the family, as well as visiting nurses or midwives. (Of course, mothers or babies with medical complications remain in hospital until they are healthy enough to leave.)

Dr. Evenson notes that the hospital case rooms have become more accommodating and have tried to address the concerns of women who want home births.

“Alberta hasn’t been the best place for home births because, in case of emergencies, hospitals are often quite far away from homes. Yet we’ve tried to make the experience in hospitals as good as possible and provide a home birth atmosphere,” he adds.

Medical science had worked diligently for many decades to move pregnant moms into the hospital to give birth, not back into the home. The medical consensus was that a well-equipped hospital was the best place for a mother to give birth to a healthy baby. The debate in society over home births was often emotional, sometimes controversial, but in the end extremely useful. It introduced and explained the important role of midwives.

“When it came to home births, the committee felt it would change the health of mothers and babies and they couldn’t support that,” says Ms Cunliffe. “As for the introduction of midwifery, the committee supported properly qualified and trained midwives.”

What the committee didn’t want were home births; yet to become a midwife in Alberta, one had to attend mothers who bore their babies at home. Ms Cunliffe notes that committee members weren’t blind to social trends, but considered them explicitly within a medical framework of what was safe and medically sound.

There was clearly a place for midwives. Their role was validated at the very meeting of the Alberta Medical Association (AMA) in 1984 that ratified the merger of the Perinatal Mortality and Maternal Welfare committees into the RCC.

The committees had discussed a team approach to patient care and the perinatal mortality committee's annual report quoted from the *Society of Obstetricians and Gynaecologists of Canada News*.⁵⁵

"In the past few years there has been a trend for fewer family physicians to assume care of maternity patients We must confront the fact that there are not enough obstetricians/gynecologists to deliver all women in Canada. Therefore, it is important to develop alternative methods of providing obstetric services. The model that has evolved in England, in which a consultant obstetrician collaborates with and directs a team of midwives, may have to be examined closely for its future application in Canada."

Dr. Fawzy H. Morcos, a past member of the RCC, was doing just that. As the chief of obstetrics at the Misericordia Hospital in Edmonton, Dr. Morcos was conducting a pilot study "to explore the possibility of experienced caseroom nurses, under the supervision of obstetricians, giving continuity of care through pregnancy, labor and delivery to a selected group of low-risk women."⁵⁶

Dr. Morcos' "pioneer work" was publicly recognized by the perinatal mortality committee as was the Misericordia Hospital, considered a "pioneer hospital in the care of mothers and babies."⁵⁷

What riled the perinatal mortality committee was "a small, but vociferous group of women (who) have been asking for midwifery-type maternity care." The doctors on the committee were worried that the Health Occupations Board (HOB) would "recognize Domiciliary Midwives (some of whom have no nursing or midwifery training) as a professional body."⁵⁸

The HOB told the perinatal mortality committee that these particular women were only a small part of the midwifery group and the larger body could well be recognized, in the future, as a professional organization.

The perinatal mortality committee was concerned and cautious in its recommendation to the AMA. "Your committee considers it important that physicians follow this trend carefully and give direction so that the future safety of mothers and newborns is not jeopardized by retrogressive rather than progressive approaches to their care."⁵⁹

Dr. Morcos vividly recalls the controversy over the licensing of midwives. "People said 'You just had to be ahead of your time.' I've laughed at defining ahead of your time. The midwifery project was important research. Every time you opened your

⁵⁵ *Society of Obstetricians and Gynaecologists of Canada News*, May/June 1984, Vol. 4, No. 3.

⁵⁶ Draft Committee on Perinatal Mortality Annual Report, 1984, p. 2.

⁵⁷ Ibid

⁵⁸ Ibid

⁵⁹ Op cit, p.3.

mouth and said midwives, they would think home births. All my talk was hospital-based midwifery.”

It took Dr. Morcos a full year to prepare for the program. He met with the government ministry of health, the board of the Misericordia Hospital and the perinatal mortality committee. They were especially nervous that his application would open the road for midwives at home births.

“It’s better to lead than to be forced against our will,” he says. “They did have to accept the midwives. I wanted to show the public that there was a place for midwifery as long as it was done in a protected environment. It was an excellent time at the Misericordia working with those midwives who were actually our own nurses with the training.”

It made sense to have midwives in hospitals especially with the high volume of births and the greater opportunity to assist in the high-risk pregnancies. It also helped to ease the pressures of overburdened obstetricians, gynecologists and family physicians.

Interestingly, today’s midwives share that burden. There still aren’t enough doctors and midwives to meet the challenges of delivery 24 hours a day, seven days a week.

“We’ve got to do things to help family physicians continue to practise obstetrics,” Dr. David Young, President of the Society of Obstetricians and Gynaecologists of Canada, explained to Susan Ruttan of the *Edmonton Journal* during the society’s annual conference in Edmonton in June 2004. “We’ve got to support midwifery education and legislation that allows qualified midwives to practise.”

The challenge to find and lead a balanced lifestyle is the main reason family doctors are leaving the delivery room. Today’s midwives are likely to follow the doctor out the door.

“I believe that if you did a survey of midwives, they would have difficulties with the same thing,” Dr. Young told Ms Ruttan. “Will they be any different from the family physicians and the obstetricians in terms of their desire to have some kind of lifestyle?”⁶⁰

Dr. Young’s solution, a team approach by doctors, nurses and midwives, is exactly what was proposed 20 years earlier by both the Society of Obstetricians and Gynaecologists of Canada and the perinatal mortality committee. The RCC had representation from the Alberta Association of Midwives for many years, with Dr. Beverly O’Brien being the final member before the RCC was merged into the Alberta Perinatal Health Program in 2004.

“The committee didn’t shy away from the hot button topics,” says Dr. Lane. “The quality of the debate was one of delicacy and diplomacy. There was respect for everyone who brought their viewpoint.”

⁶⁰ *Edmonton Journal*, June 28, 2004, p. B3.

The RCC introduced and debated the social, moral and legal anxieties wrought by medical breakthroughs that seemed unimaginable just a century ago.

“I believe that we have done ourselves a disservice with advancing technologies,” continues Dr. Lane. “We have crept up to the point where technology knows more than Mother Nature. Every time we try to solve a problem we add more technology.”

This is especially true with cesarean births. The rate has risen since 1995 to 20.2 per 100 hospital deliveries in 2000 and a new high of 23.2 in 2002. The Canadian cesarean rate was 21.2 per 100 hospital deliveries in 2000/2001.⁶¹

“That won’t change,” says Dr. Evenson. “They will keep going up. No one knows what the ideal cesarean rate is. With all the pressures, no one is going to take a chance of a bad outcome. The result will be a higher number of cesareans.”

Cesareans will also be a challenge for government. As C-section rates go up, patients stay in hospital longer, and the number of available beds decreases. While there hasn’t been an increase in maternal mortality, with the number of cesareans growing, Dr. Evenson believes there is cause for concern.

Yet there are some women who believe they can ignore the physical realities of giving birth and choose the time that’s most convenient and simply book a cesarean section. They’re called “too posh to push,” and one shudders over what they must imagine child rearing to be like.

“Cesarean section is major abdominal surgery, and consequently cesarean rates are an important reproductive health issue. Much research has been directed at determining the source of increasing cesarean rates in recent decades.”⁶²

Dr. J. Guy Gokiert, a past chair of the RCC, is also concerned about the high number of cesareans and believes the best route of birth is vaginal: “If God wanted you to deliver through your belly, He might have done something different.”

Dr. John J. Boyd calls the whole cesarean discussion “a controversial area at the moment.” He remembers starting out in 1971, when the C-section rate was between two and four percent. Now the whole area is much more complex, with women waiting to have babies until they are over 35. In addition, some gain far too much weight when pregnant.

“The trauma now is with the mothers who are going into more C-sections,” he says. “It can certainly colour a woman’s obstetrical history. From the age of 20 to 35, the body is flexible. From 35 to 45 it’s a different story. Women are designed to have their babies young.”

During the last two decades of the 20th century, many women supposed that they could control their bodies to the point where they decided where and when to have a child. For some, having a child seemed like going to a meeting. It was all about

⁶¹ Alberta Health and Wellness, Alberta Reproductive Health: Pregnancies and Births Report for 2002, p.34; Alberta Health and Wellness, Alberta Reproductive Health: Pregnancies and Births Report for 2004, p. 34.

⁶² Alberta Health and Wellness, Alberta Reproductive Health: Pregnancies and Births Report for 2004, p. 46.

control and starting a family when everything else was in place – the right job, the right money, and the right relationship.

“Obstetrics offends people who are used to control. They have to go with the flow, except for cesareans,” notes Dr. Janet E. Northcott, a family physician in Calgary. “Some older moms are making plans as if they’re shopping for a mortgage. They don’t understand that the fundamental process isn’t in our control.”⁶³

Like everything in life, what seems doable can sometimes be delusional. There is a point where biology takes over and a woman who thinks that giving birth in her 40s is as easy as in her 20s is woefully misled. Even if she does conceive – and that likelihood diminishes as she ages – the risk of a miscarriage or Down Syndrome or chromosomal abnormalities rises dramatically.

“The social and medical situations aren’t in touch with each other,” notes Dr. Northcott. “After 35, a woman’s fertility starts to drop, and by 40 it’s so significantly low that the fertility clinic won’t do it due to a very low success rate. At the age of 35, the risk of a baby with chromosomal abnormalities is 1 in 200. It’s 1 in 40 at the age of 40. The whole genetic screening that amniocentesis provides has a miscarriage risk of 1 in 200. It’s not a free lunch. By and large people over-estimate the power of medicine. They think tests are risk free. People are out of touch with reality. And they’re very angry when they discover the truth.”⁶⁴

Sophisticated diagnostics and ultrasound as well as advanced research into reproductive endocrinology have had a tremendous impact on the ability of older women to become pregnant. The increasing number of multiple births puts pressure on the hospitals as very premature babies are born at 30 weeks or less. They’re in hospital for weeks, are placed in incubators for those extended periods and often end up with long-term problems. No wonder the RCC spent considerable passion and time on the whole topic of artificial reproductive technology.

“There’s a real load on the system and this is happening a lot more than we realize,” observes Dr. Evenson. “When we review perinatal deaths, we’re seeing twin or triplet deaths at 20 or 25 weeks. These are counted, and yet the in vitro clinics are rated on their success.”

What a paradox this painful situation brings to a mother caught in technology’s twist; the bliss of becoming pregnant versus the sorrow of a premature delivery and death. Technology creates an artificial increase in the perinatal death and morbidity rate as well as in the in vitro fertilization success rate. A generation ago, in vitro and other artificial reproductive technologies were at their infancy. A delivery at 20 or 25 weeks would have little chance of life. Because Alberta’s in vitro clinics in Edmonton and Calgary are highly successful, the number of multiple pregnancies will only continue.

⁶³ Sydney Sharpe, “Middle-aged Moms,” *Apple* magazine, March/April 2004, p.17. *Apple* is a publication of the Calgary Health Region.

⁶⁴ Ibid

“Babies born of multiple pregnancies will be an ongoing problem,” continues Dr. Evenson. “We should restrict clinics to implanting just one egg. In Europe they are doing just that and are having more success.”

Yet, for many mothers who never expected to become pregnant, technology can be the blessing of a lifetime. And when technology helps create life, Alberta doctors respect it fully and do everything possible to help it survive and thrive. Nothing illustrates this more vividly than the story of Leanne and Jeff Gullekson of St. Albert, who lauded the team of Alberta doctors that made their dreams of a family a reality.

When Ms Gullekson gave birth to triplets, they were 14 weeks premature. This is what the couple wrote in the *Edmonton Journal* on October 4, 2004.

“From the moment we were told we were expecting triplets to the day last week when we took the last of our children home from the hospital, we received nothing but the best medical care imaginable.

“Any multiple pregnancy presents increased risk both to mother and babies, so we were monitored closely by many medical professionals. Additionally, we were given access to a prenatal class specializing in multiple births, an option not available in most other provinces.

“Without medical ‘interference,’ our children would not be here. Ultrasound revealed our triplet pregnancy, gave us time to take proper health precautions and provided a means to track the babies' growth. When we went into labor prematurely, constant fetal monitoring let the doctors know the children's birth could not be held off any longer. A cesarean section meant our children were born safely. ‘Interference’ meant our children were greeted by a first-class neonatal team, put on machines to help them breathe, given drugs that eased their discomfort and allowed them to grow, and given access to surgeries correcting problems that could have ended their lives. We spent five months in the neonatal intensive care unit at the Royal Alexandra Hospital. During that time our children were treated by world-renowned neonatologists and surgeons who consulted with their colleagues around the world when necessary.

“We were given access to excellent nurses, a lactation consultant and breastfeeding clinic, nutritionists, dietitians, neurologists, pulmonologists and immunologists. And at the end of it all, they handed us three healthy children.

“Obviously we feel funding for maternity and infant care in Alberta is important. Yet our experience has taught us that the true quality of care in this province is second to none. Had they been born in most other parts of the world, including some provinces in this country, our children would not be here. Medical intervention saved their lives, and for that we will always be grateful.”

The experience of Leanne and Jeff Gullekson speaks to the incomparable caliber of care provided by the doctors of this province. For a century, Alberta doctors and their organization, the AMA, have focused on accessibility and quality. The RCC and its predecessors weighed the cascade of medical breakthroughs with single-minded purpose: the care of the mother and her child. That they continue to do, with passion and dedication.

CHAPTER SEVEN

Delivering the Message: Research and Public Relations Campaigns

The Committee on Reproductive Care (RCC) was an innovator that often advocated bold moves to meet its goal of healthy mothers and babies. Gathering and interpreting statistics helped the RCC to recognize trends and determine the best care. In that role, the RCC reached into every facet of society as it sought to improve community well-being through medical attention and education.

Organizing awareness campaigns, holding news conferences, delivering research papers and publishing medical articles were important ways to publicize vital information. The RCC was very effective in getting its medical messages to the larger community. It encouraged partnerships with other health care groups and developed innovative collaborations.

“It all stems from putting patients first,” says Ronald A. Kustra, Assistant Executive Director, Public Affairs, for the Alberta Medical Association (AMA). “The idea comes from the committee where they provide the leadership. They look at health issues that need a higher profile and should be part of the public agenda.”

For example, in the 1970s, the AMA introduced a seat belt campaign that proved instrumental in getting provincial attention and legislation. From the 1970s into the 1980s, the AMA actually donated child safety seats to the families of newborns within the province. Once seat belts and baby carriers became part of the public consciousness (and mandatory) the AMA no longer needed to give them away. Prospective parents were already buying their own.

This was only one in a number of campaigns initiated by the RCC and its predecessors. The projects were readily embraced within the AMA because of the RCC’s track record of responding to crucial community needs. Committee members were quick to collaborate with colleagues from other fields whose expertise they respected. The RCC always acknowledged their help in their annual reports.⁶⁵

“The advocacy role went beyond good care for mothers and babies,” says Dr. Charlene M.T. Robertson, a pediatrician. “There were a lot of different topics that came about over the years, all related to care. The advocacy issues and statements carried quite a weight and were published and organized in the *Alberta Doctors’ Digest*. These could be done because the committee had the backing of the AMA and used its facilities for brochures and other publicity.”

The RCC became a serious advocate of health information for teenagers as well as adults, in spite of a backlash by vocal minority groups. The committee promoted sex

⁶⁵ For example, see the Committee on Reproductive Care: Funding, Operating Expenses and Activities Summary, February 27, 2001, where the RCC thanks the AMA Public Affairs Department for funding the printing and distribution of two documents: the Prenatal Care Plan and the Stillborn Investigation Protocol.

education in the schools as well as the Condom and Pill project to combat sexually transmitted diseases (STDs). It also tackled the devastating effects of alcohol and drugs on the baby in the womb.

“The RCC didn’t just talk. It provided advice to politicians and it made recommendations,” says Grace Guyon, the RCC coordinator and manager. “They took the lead on a lot of issues. Small things grew into bigger ones. For instance, the work on substance abuse developed into the project around fetal alcohol syndrome (FAS). The background work showed the committee was forward thinking. The work was very collaborative, such as the joint report on reproductive outcomes.” (Known as The Alberta Reproductive Health Report.)

The committee was a resource for groups across the province and the country. It advised the Provincial Government for its school curriculum on sex education. It became a partner in the project to educate prospective mothers about FAS.

In particular, the committee’s annual report for 1996-97 reveals a breadth of activities dedicated to informing the public and combating a range of health concerns. The RCC collaboration with other health care workers throughout the province led to a series of crucial campaigns.

Armed with a grant from Alberta Health, the RCC and its partners recommended and developed materials for the HIV Screening in Pregnancy Program. The scope of the collaboration included the AMA, the Provincial AIDS Program, women’s health groups, the Alberta Association of Midwives, the AIDS community and the College of Physicians and Surgeons of Alberta.

A joint program on alcohol related birth defects produced and distributed the Fetal Alcohol Syndrome Community Resource List. The RCC was an important contributor to the group that was led by the Alberta Alcohol and Drug Abuse Commission (AADAC). “The list provides a place to start for professionals, parents and caregivers looking for services related to FAS.”⁶⁶

Also that year, the RCC took the lead in a joint project of the AMA, Canadian Medical Association and Health Canada called *It Takes Two – The Condom and Pill Project*. It was a massive information campaign directed at adult women and physicians.

“The program assists physicians in counselling women about using condoms for protection against HIV and other sexually transmitted diseases in conjunction with other birth control methods. Program evaluation results reported strong patient and physician endorsement of this project.”⁶⁷

Candy L. Holland, Manager of the AMA’s website and publications, was involved in the Condom and Pill project and its massive campaign directed at physicians, public health nurses as well as AMA staff.

“We were trying to identify how to inform patients better on protecting themselves and not being afraid to discuss it with their partners and doctors,” she

⁶⁶ Committee on Reproductive Care Annual Report for 1996-97.

⁶⁷ Ibid

says. “We were looking at the different options available and appropriate for their lifestyle.”

The whole project, which began in 1994, solicited input from three focus groups: physicians, women between the ages of 19 and 35, and men between 18 and 35. Each of the groups explored attitudes towards safer sex and counselling.

Society had changed with the onslaught of more virulent STDs, especially those due to HIV. Sexual information went beyond birth control, the condom and the pill. The RCC wanted to inform the public on a range of sexual issues so they could protect themselves and their future children. They developed a program to help adults and physicians discuss extremely sensitive details in a comfortable environment.

How do single people become informed and how do they communicate their concerns with prospective partners? How do they respect each other’s privacy but gather intensely personal information in a non-threatening manner? How do they protect themselves against HIV infection and other STDs?

“This was a whole new education for people,” says Ms Holland. “It involved a new way of communicating with a partner and with the physician than in the past. With our program, we were trying to help patients communicate with doctors and wanted physicians to feel comfortable counselling patients. We developed quite a variety of materials for physicians and patients to use.”

The project provided a myriad of pamphlets and other printed materials, including a poster for physicians’ offices. While patients sat in the waiting room, they completed risk assessment sheets. They could read a guide on women’s risk of HIV and STDs. There was an instruction sheet on how to use a condom. Finally, there were free condoms.

While most physicians welcomed the program, some did not feel comfortable talking with patients about condoms and birth control pills. To them, that meant promoting a certain lifestyle with which they strongly disagreed. This was a moral dilemma that the project also hoped to deal with through presenting available options.

“We felt it was a very successful project,” adds Ms Holland. “Physicians used the materials, as did the patients. It made them think about things they hadn’t thought about before. We had requests from schools and got calls from public health nurses across the country, from BC to Ontario.”

The tourist industries, especially those in Banff and Jasper, also welcomed the project and posted information and provided materials for their employees. The project was a stunning success and all the evaluations pointed to its significance. In the end, there was only one thing missing to make the project a permanent reality in Alberta – money. The cost of condoms proved too high to continue with the giveaway portion of the program.

Still, the AMA and the RCC were lauded for their forward thinking in the Condom and Pill project. Nationally, the project was considered a great success by Health Canada and the Canadian Medical Association. “The program has already been implemented by community health programs in Ontario and Quebec,” notes Ms Guyon.

Many participants across the province expressed their support for the project. Their thoughts are reflected in the many observations.

“Useful, practical information for patients – especially reinforced the proper method for using condoms,” noted one doctor.

“After talking to my doctor, I feel empowered to take precautions and not put my fertility at risk,” explained a patient.

“I think it boils down to everybody understanding it’s a matter of personal responsibility,” stated a male focus group participant.

“I feel more empowered, because it is my right to make sure that my partner wears a condom and that we both protect ourselves,” declared a female focus group participant.

The RCC spearheaded many other projects to protect mothers and babies. They promoted the benefits of folic acid for women who are, or plan to become, pregnant. There was also the importance of administering Vitamin K – and ensuring that it is indeed Vitamin K – to the newborn.

The committee took a multifaceted approach to the issues of the day, partnering with community, medical and university groups. It also assumed the lead in provincial and national projects.

The Alberta Reproductive Health Report, published by Alberta Health and Wellness, is a state of the province message on pregnancies and births in Alberta. Its vital data on birth and mortality rates relied heavily on statistics gathered by the RCC. This included information that doctors, nurses and midwives completed on forms developed and updated by the RCC. The Department of Vital Statistics also used RCC data.

The RCC was intimately involved in the Newborn Screening Program, the HIV Screening in Pregnancy Program, the Prenatal Care Plan, the Breastfeeding Directory for Alberta, and the Stillborn Investigation Protocol, which was adopted in BC, Manitoba and Newfoundland.

The committee’s work with the FAS Partnership was highly influential. In particular, the RCC “conducted a physician needs assessment on FAS that has been adopted for use across the country by Health Canada,” notes Ms Guyon, adding that the FAS clinical practice guidelines are used in the prairies and parts of eastern Canada.

Crucial to the committee were education and communication. Members kept abreast of research and the latest facts in their field. They wrote papers, distributed briefs on current issues and published in the *Alberta Doctors’ Digest* as well as national and international journals. The members believed that peer review, publishing and being informed were essential to their role on the RCC. Throughout its tenure, the RCC maintained the best perinatal and maternal statistics in the country.

Once the data were analyzed and the issues were apparent, the message needed to get to other doctors and health care providers, patients and the larger community. Choosing the medium and developing the message was crucial.

Dr. Reginald S. Sauve, a member of the RCC, recalls the respect earned by the committee within the greater medical community for the caliber of the Alberta data. He cites Dr. Robert Kinch, former chair of the History and Archives Committee for the Society of Obstetricians and Gynaecologists of Canada (SOGC), and a winner of the SOGC's President's Award.

"Dr. Robert Kinch, the senior obstetrician in Montreal (at the Jewish General Hospital), has talked to me about his feeling that the work of this committee and the records from the period it has existed are extremely important in the history of obstetrics in Canada."

Dr. Sauve recalls two specific research reports that he wrote to examine infants on the edge of viability who weighed 500 grams or less. His provincial study was possible only because he was able to verify his data by using RCC statistics.

His student, Dr. Steve Wood, studied diabetic women and examined those who developed diabetes later in life. Diabetic women are known to have more problems when they become pregnant.

"Dr. Wood looked at the old records of the RCC to determine outcomes of diabetic pregnancies over the years," notes Dr. Sauve. "He was able to determine that pregnant women who develop diabetes later in life experienced an increase in poor outcomes (to their pregnancy) even before they developed diabetes."

The work of the RCC and its predecessors was rich in detailed data. Committee members were recognized for their academic and research strengths as well as their clinical and administrative work. For example, Dr. Margaret M. Hutton, Chair of the Committee on Perinatal Mortality, wrote a number of papers that were nationally respected. Here are a few:

- "Common Gynecological Disorders Related to Adolescent Development," *Alberta Medical Bulletin*, February 1952.
- "A Clinical Review of Primary Ovarian Carcinoma," *Canadian Journal of Surgery*, April 1962.
- "A Study of Perinatal Deaths as a Means of Improving Perinatal Mortality and Morbidity," *Alberta Medical Bulletin*, September 1964.
- "Toxemia of Pregnancy in Alberta from 1961-1963," *Alberta Medical Bulletin*, 1965.
- "The Proper Anticipation of Rh Hemolytic Disease," *Alberta Medical Bulletin*, 1965.
- "A Study of Social Factors Affecting Teen-Age Married Multiparae," *Canadian Journal of Public Health*, January 1968.

Dr. Lloyd C. Grisdale, another former chair of the perinatal mortality committee, published his detailed study entitled "The Alberta Perinatal Mortality Study" in the *Canadian Medical Association Journal* of February 1958. His conclusions spoke to the very purpose of the committee and his passionate commitment offered a glimpse into its future success.

“The aim of the committee has been to encourage the adoption of recognized standards of obstetric and pediatric care throughout Alberta. The committee believes that the continuation of this study will inevitably lead to an improved perinatal mortality rate.”

That it most definitely did. Yet it also led to a much wider influence in patient care throughout Alberta and Canada. The RCC and its predecessors were the first to gather the data necessary to analyze trends and recommend changes.

“Our advocacy role was fairly strong,” notes Dr. J. Guy Gokiert, a former committee chair. “It was not one where we taught people face to face but through the AMA. I congratulate the AMA in the long term. They said this was an important committee and kept it going. They published all the data and this was given to each hospital where deliveries were taking place.”

Physicians everywhere in the medical community could use these data to keep medical education current. Professors of medicine who taught continuing education courses were able to use all the RCC research. “They could offer a whole range of data that was current, tangible and occurring in our province,” added Dr. Gokiert.

The role of informing the medical world as well as the community at large was not something the committee did lightly. It wanted to ensure that its own doctors had the right documentation and follow-through procedures. If anything went wrong with a patient, the RCC members worked to give doctors the means to “hold their hands” and provide educational advice.

The ramifications of the RCC’s work spilled into all levels of society. The benefits, both obvious and subtle, were profound. Whether the RCC went public with the hot issues of the day or remained below the radar screen, it ultimately helped every mother and child born in Alberta.

CHAPTER EIGHT

The Final Tribute: The Province Creates the Alberta Perinatal Health Program

By the early 1990s, it was obvious to many experts involved in perinatal care that the old ways of ensuring health for mothers and babies were no longer good enough for an increasingly complex province. Several excellent programs were approaching similar tasks from different angles, making duplication inevitable. The work was still superb, but professionals wanted the best structure possible to continue Alberta's tradition of providing superior care and oversight.

Thus was born the proposal for an Alberta Perinatal Program that would include the expertise of several groups, including the Alberta Medical Association's (AMA's) Committee on Reproductive Care (RCC). Perhaps the most remarkable aspect of this project was the absence of territorialism. From the first proposal released in 1996 to the creation of the province-wide program in 2004, all the groups were willing to give up their stand-alone identities in the interests of best care for mothers and children.

Various aspects of perinatal care had been studied, promoted and inspected over several decades by seven organizations. Still active in 1996 were the AMA's RCC, the Southern Alberta Perinatal Advisory Committee, the Southern Alberta Perinatal Education Program, and the Northern and Central Alberta Perinatal Outreach Program.

Three other groups had worked diligently over the years but were no longer active by 1996. They included the Alberta Perinatal Program Advisory Committee, the Northern and Central Alberta Perinatal Program Advisory Committee, and the College of Physicians and Surgeons of Alberta Advisory Committee on Obstetrics and Gynecology.⁶⁸

Dr. J. Guy Gokiert, then chair of the RCC and a member of what participants called the "Group of Seven," outlined the rationale for a province-wide body when the proposal was submitted to the government in 1996:

"The existing perinatal committees have made significant strides in improving the health outcomes of Alberta women and their newborns," he wrote to Honorable Shirley McClellan, then the provincial health minister.

"In this regard, we are particularly proud of the contributions of the AMA Committee on Reproductive Care. However, recently it has become clear to many of those involved that the old ways of doing things were not as effective as they once were. Consequently, representatives, at both administrative and governance levels, of each of the groups involved, met to discuss ways of increasing the efficiency of their collective activities

⁶⁸ Proposal for an Alberta Perinatal Program: Assurance for Quality Perinatal Care, March 1996.

“The amalgamation of the functions of the existing committees under one governing body and retention of the peer review process for maternal, perinatal and neonatal mortality are, we believe, two of the strengths of the proposal. We are also very encouraged to see morbidity review being addressed.”⁶⁹

The first meeting to discuss the feasibility of a province-wide group was held in Calgary on September 14, 1994. Eight experts worked long hours on the proposal, including Dr. Philip C. Etches and Grace Guyon from the RCC. The development and secretariat of the project were jointly supported by the AMA, the Northern and Central Alberta Perinatal Outreach Program, the Southern Alberta Perinatal Advisory Committee, the Southern Alberta Perinatal Education Program, and the Alberta Association of Midwives.

In the 1996 report that emerged from this process, the group was very clear about the problem: “The functions and memberships of the various committees overlap and lead to duplication of activities, as well as the failure to address some issues. Accountability for quality of care cannot be assured due to fragmentation of responsibilities . . . There is unprecedented support and agreement that restructuring to a provincial program was required to assure quality perinatal care within a changing climate.”⁷⁰

The group laid out a clear vision for the government to follow, and endorsed it unanimously. The new Alberta Perinatal Program would be “committed to the provision of the highest quality of perinatal health service in partnership with Alberta Health, the Provincial Health Council, the regional health authorities, professional regulatory bodies, professional associations, health care professionals and related organizations by providing a mechanism to coordinate regional care, communication, education, program development and audit and outcome review.”⁷¹

The group then stated its core beliefs about the future of perinatal care, including:⁷²

1. Women and their families should have access to prenatal, intrapartum and postpartum care within their own region; and . . . a system for transfer to referral centres must be available when it becomes necessary.
2. This care is best provided by the integration of each perinatal service into the regional system through the planning and organization of perinatal health care referral patterns.
3. A coordinated and collaborative approach facilitates efforts to reduce perinatal mortality and morbidity through consultation, communication and education.

⁶⁹ Letter to Honorable Shirley McClellan, Minister of Health, from Dr. J. Guy Gokiert, February 20, 1996.

⁷⁰ Proposal for an Alberta Perinatal Program: Assurance for Quality Perinatal Care, March 1996.

⁷¹ Ibid

⁷² Ibid

4. A provincial/regional audit and outcome review provides the basis for trend analysis, program development, practice standards, guidelines, education and the identification of research questions.

These beliefs stressed yet again the view of Rachel Tasker – as well as hundreds of AMA committee members over the decades – that cooperation and communication were the keys to maternal and infant health. The study group was meticulous about planning the roles, responsibilities and lines of communication in order to bequeath these strengths to the new provincial organization. Specifically, the new province-wide body would “assist in the development of methods for communication and collaboration with other groups in Alberta concerned with perinatal health, including: The College of Physicians and Surgeons of Alberta, the Alberta Medical Association, the Alberta Association of Registered Nurses, the Alberta Pediatric Society, the Alberta Society of Obstetricians and Gynaecologists, midwives, community health agencies, regional committees and stakeholder groups.”

True to the long tradition of the AMA committees, the report placed heavy emphasis on ensuring quality of care. To continue the difficult but useful process of investigating maternal and infant deaths, the new body would “develop the mechanism for and facilitate outcome evaluation through a peer review and/or multidisciplinary review process.” It would also “analyze data and make recommendations regarding maternal, perinatal and neonatal mortality and morbidity.”⁷³ The stakeholders agreed that the core functions of the RCC should be preserved.

In the new world of powerful regional health authorities created by the province in the 1990s, the planning group knew that cooperation and integration with these health regions would be essential. Without recognition by the regions, a provincial perinatal program could easily find itself without real influence or authority. The gains the RCC had achieved through hard work and intense focus, backed from the start by specific ministerial approval, could easily be lost. To avoid this, the group stated: “Achievement of the goals and objectives of the Alberta Perinatal Program is dependent on affiliation with the Regional Health Authorities.” Those authorities would:

1. Participate in the work of the Alberta Perinatal Program through committee representation.
2. Recognize the Alberta Perinatal Program as a resource for addressing perinatal issues.
3. Support and promote a patient consultation, referral and transfer system.
4. Implement Alberta Perinatal Program standards, guidelines and policies.
5. Participate in data collection, audit and outcome review, and perinatal education.
6. Participate in evaluation of the effectiveness of the Alberta Perinatal Program.

Finally, the working group stated that “the Alberta Perinatal Program, built on the foundation of current perinatal committees/programs, has been designed to ensure

⁷³ Ibid

the highest quality of perinatal health care in Alberta. Program responsibilities include: quality perinatal care; collaboration and communication; a perinatal information system; audit and outcome review; and education and consultation. Accountability for future perinatal care in Alberta is assured through a credible and responsive Alberta Perinatal Program.”⁷⁴

Enthusiasm for the project was overwhelming. A request for support brought letters from 13 key players and organizations. Dr. Larry R. Ohlhauser, Registrar of the College of Physicians and Surgeons of Alberta, wrote that his Council “heartily extends its support for the integrated Alberta Provincial Perinatal Program . . . The benefits of this program transcends professional boundaries and Council encourages the Alberta government to commit the necessary long-range funding of a new and improved process for quality improvement in perinatal care.” Dr. Ohlhauser also made a diplomatic plea for measures to ensure the program’s success: “It will be important that all perinatal care providers participate in outcomes measurement and that legislation will permit access to databases needed by the program.”⁷⁵

Dr. John F. Jarrell, Senior Medical Officer of Acute Care for the Calgary Regional Health Authority, wrote: “I think the document recommending an Alberta Perinatal Program is excellent and if adopted would serve as an excellent resource to the services provided by regional authorities.”⁷⁶

Dr. Etches, a past chair of the RCC, endorsed the plan in his capacity as associate chief, Department of Newborn Medicine, at Edmonton’s Royal Alexandra Hospital. “As one of the stakeholders originally responsible for developing this proposal, I am writing to express my support for this document in the hope that it will be given very serious consideration. I think that this proposal represents the way forward to maintain and improve the outcomes for pregnant women and their babies in Alberta.”⁷⁷

Dr. Ian R. Lange, the chief of obstetrics at Calgary’s Foothills Hospital, weighed in with some astute observations. “Alberta has come a long way in providing excellence in perinatal care and this is revealed in current perinatal statistics,” he wrote. “However, I think that the time is appropriate to consider streamlining the organizational structure within the province. I think this need is now greater as there is a real possibility of perinatal fragmentation with the introduction of 17 regional health boards. It is possible that this fragmentation may ultimately lead to confusion in standards of care and adverse maternal and/or perinatal outcomes.” Dr. Lange concluded, “I fully endorse this proposal.”⁷⁸

Dr. Bryan F. Mitchell, Chair of the Department of Obstetrics and Gynaecology at the University of Alberta Medical School, endorsed the proposal but sounded some alarm bells. He wanted the new body to have a permanent staff “because, without such

⁷⁴ Ibid

⁷⁵ Letter from Dr. Larry R. Ohlhauser to Grace Guyon, December 19, 1995.

⁷⁶ Letter from Dr. John F. Jarrell to Grace Guyon, August 21 1995.

⁷⁷ Letter from Dr. Philip C. Etches to Honorable Shirley McClellan, Minister of Health, August 8, 1995.

⁷⁸ Letter from Dr. Ian R. Lange to Grace Guyon, August 3 1995.

full-time positions, I am quite certain that any new structure will eventually fragment into small groups with special interest foci.” He was also disappointed that there was little mention of liaison with the provincial medical schools at the University of Alberta and University of Calgary. And Dr. Mitchell wanted the province to ensure that during the transition period to a new program, funding would continue for the existing ones. Ultimately, though, he too was in favor. “Once again, I pass along my congratulations to the group on a job well done,” he wrote. “I hope the ministry will see fit to move forward expeditiously.”⁷⁹

Despite this plea for action, more than eight years would pass before the province created the program. During those years, the existing bodies, including the RCC, continued their work in an increasingly complex environment. But the government was not neglecting the proposal; indeed, it commissioned a massive review of perinatal care from McDermott & Associates Consulting Inc. The RCC made a major contribution to this provincial study. The eight-member advisory committee to the Alberta Perinatal Program Review included Grace Guyon, coordinator of the RCC; two past chairs, Dr. Philip C. Etches of Edmonton and Dr. William R. Young of Red Deer; and Dr. Nestor N. Demianczuk, Head of the Women’s Health Program at the Royal Alexandra Hospital, who had been involved with the RCC.

The full review, which includes fascinating comparisons with programs in other provinces and countries, was presented to the government on March 17, 2000. Not surprisingly, it concluded that a provincial program should be created, and should include all the functions requested in the 1996 report including data collection and analysis, as well as review of maternal and infant mortality and morbidity. The review also strongly recommended that the provincial program have its own staff and budget.⁸⁰

Four years later on July 1, 2004, the province formally created the Alberta Perinatal Health Program as a four-way partnership among Alberta Health and Wellness, the AMA, Calgary Health Region and Capital Health. The new body had its own staff, including members of the previous committees, an initial budget of \$6.5 million, and an experienced director, Corine Frick.

Some RCC veterans have reservations about the new order of things. Dr. Charlene M.T. Robertson says: “I don’t know what will happen with the Alberta Perinatal (Health) Program; it is unlikely, unless it has a subcommittee similar to that of the RCC, to do a peer review. Policies are broad. They don’t seem so interested in our outcomes of neonatal care . . . There was lots of strength in the old reports. There was so much individual information that could be looked into and compared to other hospitals. (Now) the concept of learning from your data seems to have been lost in favor of a more general approach.”

⁷⁹ Letter from Dr. Bryan F. Mitchell to Grace Guyon, April 25, 1994.

⁸⁰ The Proposal for an Alberta Perinatal Health Initiative: Healthy Moms, Babies . . . Futures, the Report of the Alberta Perinatal Program Review, March 17, 2000.

Dr. Carolyn A. Lane feels the transition will be difficult “because the RCC has been a very accomplished committee.” After the RCC, working in a government structure is bound to be frustrating for some. The RCC saw a problem, found a solution and implemented it, she says, and “we have to keep that simplicity going.” Dr. Lane believes, however, that the new group is open to solutions and peer review “can still occur outside the doctors’ club.”

Ms Guyon is optimistic that the provincial program can build on past achievements, and she is confident that the RCC peer review process will continue.

“Change has to happen, although it can be difficult,” she says. “It is evident that the government is supporting the new perinatal health program and that it is well funded. We’re building on the successes of the past as we move to the future.”

The concept, planning and implementation of the new agency are certainly positive. All the resources for perinatal monitoring, education and review are finally concentrated in one body, for the good of mothers and babies all over the province. Without doubt, the roots of the Alberta Perinatal Health Program go back to the physicians’ committees on maternal and infant health created in 1936, 1954 and 1984. Few would deny that this new provincial program was born through the passionate volunteer efforts of Alberta physicians, with the enduring support of the AMA.

One thing is absolutely certain. Having started all the groundbreaking studies of mothers and babies, and then pressed for a province-wide body to continue the work, the doctors of Alberta will now be determined to nurse this infant to good health.

CHAPTER NINE

Doing the Right Thing: Successes and Accomplishments

That the Committee on Reproductive Care (RCC) was ahead of its time is well known, but the breathtaking distance of its lead is somewhat more difficult to grasp. The Committee on Maternal Welfare began gathering detailed statistics in 1936. That committee and its successors never flagged in their determination to know everything that could be known about every case of maternal or infant death and illness. Alberta doctors, through their own organization formed in 1906, were almost alone in recognizing the value and necessity of developing data and identifying trends in order to improve care.

“Alberta has been doing this since the 1930s,” states Dr. Reginald S. Sauve. “Yet there had never been a national review of maternal deaths. Finally the Federal Government released one in 2004.”

Health Canada published its special report nearly 70 years after Alberta doctors produced their first. There is no other province in Canada where doctors have gathered and analyzed data with this degree of precision. The Alberta Medical Association (AMA) statistics are beyond comparison and priceless to researchers wherever they are.⁸¹

“Alberta was the envy of Canada,” says Dr. John J. Boyd. “I would take these figures to the Canadian (medical) meetings and they couldn’t produce anything like this. And naïve little me took the figures to meetings in the US but they couldn’t hold a candle to our provincial figures.

“Every hospital that was doing obstetrics completed their annual reports and it was quite remarkable. All the administrators worked very hard. Obstetrics, as opposed to many other disciplines in medicine, has been very good at looking at outlooks and results and trying to improve things.”

At one point, Dr. Boyd brought his research to an international conference in Scotland. When he presented his data on delivering risky babies in small hospitals, he realized that other countries were comparing figures that used different systems and definitions.

“So many countries didn’t register smaller births so it was difficult to compare figures efficiently,” he explains. “Our definition of birth was far reaching. Any pregnancy over 20 weeks and/or 500 grams was a registerable birth. There are many countries that use 28 weeks and some have moved to 24. All those years ago, we set it back to 20 weeks, and hoped that technology would get better.”

⁸¹ See Health Canada: Special Report on Maternal Mortality and Severe Morbidity in Canada – Enhanced Surveillance: The Path to Prevention, 2004, p. 10–11.

That's exactly what has happened, which is another reason why the RCC statistics are so remarkable. To be able to track the births and deaths of mothers and babies over such an extensive period provides a wealth of information.

"I think the AMA, working with the obstetricians and the committee, were very far-sighted a long time ago, many years before others kept these meticulous figures," Dr. Boyd adds.

The RCC was a collaborative group and the decades of working with other health care professionals paid off. Hospital administrators were more likely to cooperate, even though it meant extra work, because the rewards were obvious and tangible.

"We were able to give feedback to physicians and midwives. We would talk with them and make recommendations," says Dr. Sauve. He points out that the RCC, through its reviews, increased awareness in perinatal care across the country. "Dr. Robert Kinch has said what a gold mine of information the RCC has."⁸²

Dr. J. Guy Gokiert was involved with the committee before it became the RCC. He and many others know that every member was committed to improving the care and health of mothers and babies in the province. That dedication built credibility that gave the RCC wide influence in the community and with the government.

"We became more formalized in our data collection," recalls Dr. Gokiert. "We were a credible source of information and were more knowledgeable about what the data was saying and how we could apply it. We were better organized in our teaching and better able to stimulate discussion with the data. Over time, people were able to use it.

"We were able to start and build a data base representative of what was going on in the whole province. We were at the forefront in collecting data and presenting it in a well thought-out way to influence change. We were a leader in what was going on in the rest of the country."

Through its diligence and data gathering, the committee members made recommendations for changes that they could quickly justify. They influenced the quality of medical research in Alberta and beyond. Their data was used directly in the medical classrooms as well as the hospital case rooms, the doctors' offices and beyond, into government offices. Dr. Gokiert points out that the committee's data wasn't a stale study that sits on a shelf, but living and influential documents that brought important medical and legislative changes.

Committee members weren't prepared to wait and see. They were proactive, rather than passive, in their approach to patient care. Part of the reason for this tenacity was the dedication and determination of Rachel Tasker, the committee's long-time executive secretary and coordinator.

"When I started with the committee we had Rachel Tasker and she was a real task master," remembers Dr. Gokiert. "She was a midwife and wanted to bring her

⁸² Dr. Robert Kinch was chair of the History and Archives Committee of the Society of Obstetricians and Gynaecologists of Canada.

thoughts forward. Sometimes she could be quite abrasive. We were always trying to go forward and think of better ways to do things. Even at her stage in her career she was always pushing the envelope and getting lots of resistance. With medicine being as conservative as it is, she was always saying ‘we’ll try and change.’ You don’t expect it overnight. She wanted change in six months and it took five and 10 years for things to slowly evolve.”

When he first became involved, Dr. Fawzy H. Morcos felt there was little interest in the depth of the committee’s database. Instead of being discouraged, he and his colleagues simply asked for more information on the perinatal sheets and introduced lifestyles questions. Dr. Morcos also stressed the value of education and conferences where committee members would discuss their data.

In its early years, the committee was sometimes considered a nuisance and even berated by those who had to compile the data. In time, the value was recognized and almost everyone in the health system began willingly to compile the necessary statistics. The information grew into a sophisticated database with relevance that sometimes wasn’t even predicted before new technologies were created.

“We didn’t anticipate that we were going to have the services we have now,” notes Dr. Gokiart. “The RCC was part of a wave that comes forward. The universities decide they need more knowledge-based information for the pediatricians and obstetricians. We were part and parcel of looking at it. I don’t know if we were on the crest of a wave or just helping it go along.”

They were most definitely ahead of their peers across the country and beyond, but there was never any thought of relaxing. After years of collecting and analyzing the best database in Canada, the committee took the next logical step in improving patient care. The members looked beyond the immediate cause of death and began to consider associated diseases as well as other health problems. They developed medical and social solutions to preventing disease and death. They promoted responsible health choices and lobbied for change.

“The committee’s accomplishments were its strengths and its ability to move forward and change with the times,” says Dr. Carolyn A. Lane. “Its archives are a wealth of information for the future. Its fantastic statistics are the envy of other places in the country. The RCC became a multidisciplinary team and not just a doctor’s organization. There’s no way it could have accomplished what it did without teamwork and respect for everyone there.”

Dr. Lane cites the successes of the Condom and Pill project, the work on fetal alcohol syndrome (FAS), HIV screening and the joint report with Alberta Health.

Dr. Charlene M.T. Robertson was instrumental in using the perinatal database to examine the ways in which lifestyle factors such as alcohol and drug use affect pregnancy and beyond. Her work on FAS in babies and children is recognized across the country.

She respected the RCC’s role as an advocate of change to better the health of mothers and children. She also lauded their work in developing the guidelines for

resuscitation, which generated much discussion when originally introduced at an RCC meeting. The structure of the RCC was another strength because rural physicians were part of the mix.

“Having a committee with rural physicians was important because it improved care just by its very being,” says Dr. Robertson. “They came into the city, learned, went back to their communities and improved health care there.”

Dr. Gokiert, who practises in Westlock, heartily agrees. While those who live in the country rarely consider themselves isolated, they do know they’re a bit secluded from the city’s large medical facilities. The RCC played a prominent role in bridging the rural-urban divide. Its data was distributed to doctors throughout the province, who were able to contribute and act. The RCC gave rural doctors and nurses sophisticated information that they could quickly use with their patients. The rural doctors also have speedy lines of communication with their colleagues in the city hospitals and universities.

“In the rural areas, it got us more aware of techniques and care that had to be done,” says Dr. Gokiert. “It helped get ultrasound and develop greater awareness with our patients. We were able to aid pregnant mothers in a more aggressive fashion and look at what was happening in perinatal care (at the hospitals and universities).”

Rural doctors are now able to provide their pregnant patients with a high standard of care, especially those who need more monitoring. If there is any indication of complication the patient can be transferred – quickly, if necessary – to a city hospital.

For Dr. William R. Young, the RCC was a respected and recognized resource on issues of reproductive care for all Albertans, as well as physicians, nurses, midwives and other care providers.

“It was also respected across Canada,” adds Dr. Young. “The RCC reviewed tough cases and bad outcomes in a non-threatening manner with a view to educating and avoiding recurrences. We weren’t looking for blame. The committee was very positive and always composed of people with goodwill who worked towards a common cause. You came away from committee meetings feeling that you’d learned something from the others who were there.”

Dr. Philip C. Etches was proud of the peer review system that was pioneered by the predecessor committees to the RCC. If a mother or baby died and there was any concern over the quality of care provided, the attending physician could be invited to an RCC meeting. Those meetings were sometimes laden with sadness and tears, as everyone searched for ways to ensure such a tragedy wasn’t repeated. The cause was often beyond the doctor’s control, but that didn’t mean the committee members weren’t powerfully affected. And the doctors involved often berated themselves emotionally when tragedy struck.

“In a well-regulated system there has to be – and has to be seen to be – a quality improvement process,” says Dr. Etches. “It has to look at bad outcomes and

see what we can do better. You are better off to regulate yourself, do it properly and transparently in an open fashion. Otherwise, you'll be subject to criticism.

"We were a committee of the AMA and were under the rubric of how the AMA related to the outside world. There was never a problem. The AMA's mandate was to make sure that the doctors provide the best care to the public."

The RCC always had a province-wide focus. Each of the larger hospitals had its own perinatal committee that would hold its own initial reviews. Where necessary, the review would then go to the RCC. In addition, the RCC provided the service completely for the rural hospitals where obstetric consultants would examine each case. Through its provincial review, the committee was able to discover trends and systemic problems. Members could then develop solutions and provide recommendations that were adopted province-wide.

"There was a network and we thrashed out what we saw as peer review and what it achieved," notes Dr. Etches. "Certain things are best done at the local level. It gets problematical in a small centre where there are only six doctors and one person has to sit and discuss the situation and death with five friends."

The committee devised a number of ways to alleviate the problem and designed a system that made sure no one felt compromised.

"People value that there is a process and things don't get swept under the carpet," adds Dr. Etches. "We try to keep it reflective as it is a committee of experts and peers. What gets really emotional are the mothers' deaths and it is a real tragedy. A peer review provides a sense of closure. All that you can say to a family is that this death will be reviewed."

The committee could only discuss the case and recommendations with the doctor. The *Alberta Evidence Act* and the *Hospitals Act* protected those who reported to the committee from being subpoenaed or sued. That meant a far more open discussion of events than if there was a prospect of immediate legal liability.

"Physicians were able to share very freely," says Pemme Cunliffe. "Most people didn't even know this review went on. Even if we wanted to give information to people outside, we couldn't. Because the committee had that kind of access, the peer review practice was instrumental in improving outcomes for mothers and babies."

The approach was educational rather than punitive. Physicians who participated were not threatened with losing their licences. Free and open disclosure meant that every death was examined in detail to determine the cause and recommend necessary change.

"There were certainly times when there was care-giver error and that was recognized," added Ms Cunliffe. "And I'm sure that error didn't happen again. Some of these RCC meetings were emotional. The physicians who came to the meetings were often distraught because they cared so much."

The RCC became much more involved in difficult case reviews than it had been. The neonatal consultant would review cases and then bring them forward. Besides gathering statistics, the RCC pressed a range of perinatal health issues, including teen

sexuality and FAS. The members established standards for care that were especially helpful to rural doctors who didn't have immediate access to quick medical opinions.

The RCC provided guidelines on a range of issues such as: gestational diabetics; ways to manage women with pre-eclampsia or pregnancy-induced hypertension; obesity and pregnancy; cesarean sections; vaginal birth after a C-section; epidural services; multiple births; induction of labor.

The RCC was always responsive to community groups hoping for better care. In letters to the public, the RCC chair or representative was appropriate, positive and non-judgmental even though the issues could be controversial.

Here is a small sample of the range of topics that the RCC covered in its correspondence from the public: neonatal metabolic screening; Alberta hereditary disease program; hemorrhagic disease of newborn; female genital mutilation; family planning; early discharge of patient; cord blood; birthweight; circumcision; infections; resuscitation; induction of labor; analgesia; contraceptives and lactation; breast feeding; breech delivery; teenage sexuality; homosexuality.⁸³

"The committee was a resource for people to bring issues to the table that needed support such as a change in government policy or direction," says Grace Guyon, the last RCC manager. "For example, HIV screening and pregnancy. There is a drug that will prevent transmission to the newborn. Hence the committee went to the government to develop a policy on HIV screening."

Another great committee success was developing a province-wide transportation and tertiary care system in the 1970s. This meant that pregnant moms could be moved by airplane, helicopter or ambulance to the hospital that could provide the best care. Providing nurseries with neonatal ICUs offered a mother and her baby the best possible outcome and care.

Ms Guyon recalls these key events as important RCC successes: tertiary care and transport; screening for diabetes in pregnancy and managing of moms with diabetes; screening and treatment for Group B streptococcus infection; RH negative disease; HIV screening; FAS.

"The committee took an advocacy role and peer reviews were the impetus for bringing all these issues forward," says Ms Guyon. "It was a resource for other groups and provided consultation and advice. The committee wanted better reproductive health."

To that end, it led a number of far-reaching initiatives such as: sex education in the schools; the Condom and Pill project to reduce sexually transmitted diseases; the FAS disorder program to recognize and care for afflicted infants; and the recognition and support for trained and registered midwives.

The RCC continued its decades-old mandate of gathering data by developing and revising standard perinatal forms for prenatal care and care of the newborn.

⁸³ See Box 9, RCC correspondence, AMA archives.

“The RCC work was always collaborative,” notes Ms Guyon. “It couldn’t have been done without the medical records departments in the hospitals who worked very hard to provide key information, the Medical Examiner’s office, the Department of Vital Statistics. Alberta Health and Wellness was the source of some funding and provided the mandate.”

Dr. Young was co-chair of the team that developed HIV screening for mothers. The program, which brought him a great sense of personal satisfaction, was considered ahead of its time. Again, the RCC led the way across the country.

Dr. Young believes the RCC was so successful because of its longevity and its members’ broad range of experience and expertise. There was mutual respect and common purpose. In addition there was also a designated coordinator for the committee, which was “terrific for providing continuity”. From Miss Tasker as the first coordinator in 1954, to Ms Cunliffe, who took over in 1984, to Ms Guyon, the manager after 1991, the RCC was guided and prodded by coordinators who were overwhelmingly dedicated and disciplined.

The major challenge to the RCC and its predecessors was funding. Miss Tasker built important relationships within government departments so they were aware of the program. Her successors continued this crucial line of communication so that the value of the committee’s work would be recognized, always allowing it to move to the next stage.

Perhaps the greatest tribute to the RCC was that the province adopted many of its goals and methods in a new province-wide government initiative, the Alberta Perinatal Health Program. “We managed to become the architect of our own demise,” says Dr. Etches. “The great benefit is that the new program has government money. We are optimistic.”

The Alberta Perinatal Health Program is multidisciplinary (another precedent established by the RCC) and has broadened the RCC’s mandate. While RCC members are hopeful, some worry that because it’s part of government, the new committee could lose some of its ability to make precise recommendations and act upon them quickly.

Dr. Young points to the lead role that the RCC played in developing the Alberta Perinatal Health Program by first recommending such a collaboration in March 1996. He’s also pleased that they kept the provincial rather than regional focus.

“They have been able to recognize the need to keep reproductive services together in the face of regionalization,” says Dr. Young. “When it comes to case review, they should also keep the educational focus rather than seeing it as disciplinary. We’re not looking for blame. We’re looking to avoid recurrences. That was one of the real strengths of the RCC.”

Now it’s time to build on the successes of the past. The RCC was at the forefront of social and medical issues. Its agendas were packed and sometimes very controversial and emotional.

“Over the years, the committees had some colorful characters,” says Ms Cunliffe. “They were people who were good practitioners, very knowledgeable, with lots of forward-looking ideas. They felt free to share their expertise and views and they called a spade a spade.”

The RCC did highly technical work, but in the end it was really about nothing more complicated than good people and their dedication to a compelling cause. A defining image, touched by a hint of sadness and loneliness, springs to mind: Miss Tasker working in her office on Christmas Eve, resisting the urge to look when snowballs tapped at the window. She had work to do.