



Evidence Boost

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*A series of essays
highlighting
evidence-informed
management and
policy options*

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Allow midwives to participate as full members of the healthcare team

The Problem: A national shortage of maternity care providers

Your family doctor just delivered the good news—you're going to have a baby. Congratulations! Unfortunately that's all she'll be delivering, since she's one of the 70 percent of family doctors in Canada who don't attend births anymore.ⁱ Moreover, finding a specialist obstetrician may be difficult, as they tend to concentrate in urban areas and are already working beyond their capacity.ⁱⁱ

Fortunately, there is another option to a family doctor or obstetrician. For women at low risk of complications, midwives are safe and effective practitioners who could address the current shortage. Yet regulation and funding in Canada's provinces and territories are not standardized: four provinces and one territory do not certify or fund midwives; two provinces that do regulate midwives do not pay for their services; and one territory does not have legislation certifying midwives but funds them in certain circumstances.

Strategy for Change

For residents of Ontario, British Columbia, Manitoba, Quebec, the Northwest Territories, and Nunavut, provincial/territorial insurance plans provide funding for services provided by midwives—however, even in these jurisdictions there are not enough midwives to meet demand for their services. (Midwives also practice widely throughout the European Union, Australia, and New Zealand, where they have

been studied extensively.) Midwives in the other Canadian provinces and territory are working to obtain regulation and/or funding by provincial governments but have been unsuccessful to date.ⁱⁱⁱ

Research Base

In numerous studies across Europe, North America, Australia, and New Zealand, midwifery has been shown to be safe and effective in managing low-risk births in three different settings: hospital-based delivery units; stand-alone birthing centres; and at home. Low-risk mothers and their babies who are cared for by midwives fare as well as those cared for by doctors, with similar neo-natal mortality rates in all three locations. Women with high-risk pregnancies, such as those having twins, or who develop complications, such as high blood pressure, are referred to doctors.^{iv-xix}

While the clinical outcomes are comparable, birthing mothers who are cared for by midwives are much less likely to use drugs for pain relief or undergo surgical interventions, particularly if they give birth at home or in a stand-alone birthing centre. Use of an epidural, or spinal anesthesia, happens for about five to eight percent of low-risk women cared for by midwives, while doctors in hospitals use them almost 20 percent of the time for mothers with similar risk profiles.^{xiii, xv} Episiotomies (surgical incisions to prevent traumatic tearing during delivery) were performed about 14 percent of the time in birthing centres, versus 35 percent of the time in

hospital deliveries.^{ix, x} Midwives are also more likely to allow the baby to be born without the use of forceps, vacuum extraction, or other interventions—80 to 90 percent of midwife-delivered babies are born without intervention, compared to 60 to 70 percent of doctor-delivered babies in some studies.^{ix, xiii, xvii} Women being cared for by midwives are also significantly less likely to have their labour induced through medication and are less likely to have a caesarean section.^{iv, vi-x, xiii, xv, xvii}

Women who choose midwives tend to be very satisfied with their care.^{xx} A North American study found 98.7 percent of mothers who used a midwife would choose a midwife for the birth of their next child.^{xv} In England, a comparison between the care provided by midwives and obstetricians found that mothers who used midwives were significantly more satisfied with their care than a comparison group that had used obstetricians. They appreciated having options for where they can give birth, the quality of their pre-natal classes and health checks, the information and attention they received during labour, and the ongoing support they received after the birth.^v Finally, midwives provide

excellent continuity of care, meaning women often see one midwife or team of midwives throughout their pregnancies and births; this is associated with good clinical outcomes and greater satisfaction on the part of the mothers.^{xvi, xviii-xix, xxi-xxii}

Conclusion

Midwives are safe and effective caregivers for women with low-risk pregnancies. Yet the reluctance of some provincial governments to regulate the profession and/or pay for midwifery services could prevent many pregnant women from receiving this high-quality care. The challenge of eliminating regulatory and insurance barriers, along with overcoming difficulties in obtaining hospital admitting privileges and the acceptance and support of other front-line clinicians, remains.^{iii, xxiii, xxiv}

Strikingly, one of the most positive statements for the integration of midwifery into Canadian healthcare systems comes from the national society representing obstetricians, which noted in 2003 that “the integration of midwifery into the obstetrical health-care team is fostering excellence in maternity care for Canadian women and their families.”^{xxv}

References

- i. Reid AJ et al. 2000. “Family physicians in maternity care: Still in the game? Report from the CFPC’s Janus Project.” *Canadian Family Physician*; 46: 601-6, 609-11.
- ii. Society of Obstetricians and Gynaecologists of Canada. 2005. “Impact of inadequate prenatal care on neonatal mortality will rise in Canada.” www.sogc.org/media/advisories-20050620f_e.asp.
- iii. Kornelsen J. 2003. Solving the Maternity Care Crisis: Making Way for Midwifery’s Contribution. British Columbia Centre of Excellence for Women’s Health. www.bccewh.bc.ca.
- iv. Hundley VA. 1994. “Midwife managed delivery unit: a randomized controlled comparison with consultant-led care.” *British Medical Journal*; 309(6966): 1400-1404.
- v. Spurgeon P et al. 2001. “Antenatal, delivery and postnatal comparisons of maternal satisfaction with two pilot Changing Childbirth schemes compared with a traditional model of care.” *Midwifery*; 17(2): 123-132.
- vi. Campbell R et al. 1999. “Evaluation of midwife-led care provided at the Royal Bournemouth Hospital.” *Midwifery*; 15(3): 183-193.
- vii. Bodner-Adler B et al. 2004. “Influence of the birth attendant on maternal and neonatal outcomes during normal vaginal delivery: A comparison between midwife and physician management.” *The Middle European Journal of Medicine*; 116(11-12): 379-384.
- viii. Biro MA et al. 2000. “Team midwifery care in a tertiary level obstetric service: A randomized controlled trial.” *Birth*; 27(3): 168-173.
- ix. Jackson DJ et al. 2003. “Outcomes, safety, and resource utilization in a collaborative care birth centre program compared with traditional physician-based perinatal care.” *American Journal of Public Health*; 93(6): 999-1006.
- x. David M et al. 1999. “Perinatal outcome in hospital and birth centre obstetric care.” *International Journal of Gynecology and Obstetrics*; 65(2): 149-156.
- xi. Gottvall K et al. 2004. “Safety of birth centre care: perinatal mortality over a 10-year period.” *BJOG: an international journal of obstetrics and gynaecology*; 111(1): 71-78.
- xii. Garite TJ et al. 1995. “Development and experience of a university-based, freestanding birthing centre.” *Obstetrics and Gynecology*; 86(3): 411-416.
- xiii. Janssen PA et al. 2002. “Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia.” *Canadian Medical Association Journal*; 166(3): 315-323.
- xiv. Wieggers TA et al. 1996. “Outcome of planned home and planned hospital births in low risk pregnancies: prospective study in midwifery practices in the Netherlands.” *British Medical Journal*; 313(7068): 1309-1313.
- xv. Johnson KC and BA Daviss. 2005. “Outcomes of planned home births with certified professional midwives: large prospective study in North America.” *British Medical Journal*; 330(7505): 1416-22.
- xvi. Biro MA et al. 2003. “Satisfaction with team midwifery care for low- and high-risk women: a randomized controlled trial.” *Birth*; 30(1): 1-10.
- xvii. Shorten A and B Shorten. 2000. “Women’s choice? The impact of private health insurance on episiotomy rates in Australian hospitals.” *Midwifery*; 16(3): 204-212.
- xviii. Waldenstrom U et al. 2000. “Does team midwife care increase satisfaction with antenatal, intrapartum, and postpartum care? A randomized controlled trial.” *Birth*; 27(3): 156-167.
- xix. Homer CS et al. 2002. “Women’s experiences of continuity of midwifery care in a randomised controlled trial in Australia.” *Midwifery*; 18(2): 102-112.
- xx. Harvey S et al. 2002. “Evaluation of satisfaction with midwifery care.” *Midwifery*; 18(4): 260-267.
- xxi. Hodnett ED. 2000. “Continuity of caregivers for care during pregnancy and childbirth.” *Cochrane Database of Systematic Reviews*; 1(CD000062).
- xxii. De Koninck M et al. 2001. “Comparing women’s assessment of midwifery and medical care in Quebec, Canada.” *Journal of Midwifery and Women’s Health*; 46(2): 60-67.
- xxiii. Kornelsen J. 2000. Pushing for Change: Challenges of Integrating Midwifery into the Health Care System. British Columbia Centre of Excellence for Women’s Health. www.bccewh.bc.ca.
- xxiv. Kornelsen J et al. 2003. “On the road to collaboration: Nurses and newly regulated midwives in British Columbia, Canada.” *Journal of Midwifery and Women’s Health*; 48(2): 126-132.
- xxv. Society of Obstetricians and Gynaecologists of Canada. 2003. “SOGC policy statement: Midwifery.” *Journal of Obstetrics and Gynaecology Canada*; 25(3): 239.