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Midwifery and home births

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Those of us who qualified in obstetrics in Commonwealth or European medical schools learned midwifery, or practical obstetrics, from experienced midwives. Traditionally, the midwife has been an autonomous professional. She works within certain limitations that in Britain are imposed by an autonomous board of midwives that grants state certification for midwifery.

The article by Catherine McCourt in this issue of *CMAJ* (starting on page 285) points out that the issue of home births is quite separate from that of legalizing midwifery. At a recent symposium sponsored by the Society of Obstetricians and Gynaecologists of Canada, Professor Jelte de Haan, director of one of the three midwifery training schools in the Netherlands, highlighted the Dutch experience. He prefers that midwives be trained for 3 years in midwifery rather than be nurses with added midwifery training. Enthusiasts for domiciliary midwifery consider the Dutch experience to be the pinnacle of excellence, but de Haan stated categorically that planned home births are more dangerous for both the mother and the infant than births in hospital. He claimed that the selection process used to identify women at low risk of complications cannot predict the outcome very well, and in any case its use is not mandatory, so many twins, babies in breech presentation and babies weighing less than 2500 g are still delivered at home. Roughly 50% of these women need to be referred to hospital, usually during labour or delivery. De Haan prefers the idea of "outpatient" delivery, in which the patient delivers in hospital and is discharged home very soon after the birth of the infant. This system is being looked at in several units in Canada.

The autonomous midwife — frequently self-trained — is a major anomaly in Canadian health care. the Association of Ontario Midwives has about 135 members. Cheryl Anderson,[1] who before she became a physician was a self-taught midwife, feels that home births should be implicit in the revival of midwifery. Over 200 midwives, many self-taught, have provided care for thousands of women in their homes over the past 15 years in Canada. This is a situation that organized medicine, nursing and properly trained midwives should not contemplate with satisfaction.

Midwifery is legal in the United States, but many practitioners are nurse-midwives who act as handmaidens to family physicians and obstetricians and rarely have complete responsibility. However, there are exceptions: the University of Southern California has good facilities for training midwives, and there is excellent cooperation between midwives and residents in obstetrics. The midwives handle a large volume of patients, most of them indigent.[2]

What do adequately trained Canadian midwives want? McCourt defines midwifery accurately in her article: the midwife will settle for nothing less than being trained to be responsible for prenatal care, delivery of the low-risk patient and postpartum care. This is her right and her proper objective.

I believe that midwifery should be legalized in Canada, and that the self-taught midwife should cease to exist.

If midwives are to be recognized they must first set up a board of accreditation along the lines of the British system, preferably in cooperation with obstetricians. This board should produce a curriculum and a complete training experience. The midwives will then have to persuade provincial governments to recognize their validity and accredit them as a group of professionals. This will

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eliminate the self-taught midwife as a health care provider.

The fees for midwives' services would have to be negotiated with each provincial government. Malpractice insurance could be another difficulty, but if home births are eliminated and not recognized by the governments, all midwifery would have to be carried out in hospitals whose malpractice insurance could cover midwives' work.

The acceptance of midwives in Canada depends to a great extent on the projected demand for their services. Recent manpower studies suggest that there may be a shortage of obstetricians and gynecologists in the future (Association of Professors of Obstetrics and Gynaecology of Canada: unpublished data, 1985). There are also anecdotal reports of family physicians' abandoning obstetric practice, partly because it is difficult to integrate it into their other family practice activities and partly because of increasing malpractice insurance costs.

Legalization of midwifery would mean that the whole structure of Canadian obstetric care would have to be examined. Pivotal elements are the family physician, the obstetrician who acts as a consultant to the family physician in small centres, and the specialist in urban centres who may function as a family physician for mothers. The Canadian medical profession will only support legalization of practice by independent midwives if Canada adopts the same hierarchy as that in Britain and Europe. This means that there must be interaction between the consultant, the general practitioner and the midwife working in hospital with low-risk patients, and few or no home births.

Where will the midwives in Canada be trained? To add them to the diminishing pool of obstetric patients in recognized teaching hospitals, where they will fall over the feet of medical students, interns and residents competing for clinical care of the patient, would be counterproductive, and midwives would remain on the lowest rung. There are also philosophical differences between physicians training midwives and midwives training midwives. The best solution would be to train midwives in the many suburban hospitals, which have excellent obstetricians, and in the community hospitals in medium-sized cities, where obstetric patients are cared for by competent physicians and obstetric nurses.

I predict, and hope, that midwives in Canada will not remain as obstetric nurses, handmaidens to physicians, but will have the strength to bloom as independent professionals. Midwives have a formidable task in defining and organizing their profession. However, if the consumer demand for midwifery services continues and if the medical profession begins to feel the shortage of trained obstetricians, the governments concerned may see midwifery as a more economical model for making good obstetric care available, and midwives will be coming in on a favourable tide.

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