



Interprofessional Collaboration

Scope of Practice Review: Midwifery

Summary & selected highlights from the literature

August 2008

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Background

In June 2007, the Minister of Health and Long-Term Care requested the Health Professions Regulatory Advisory Council (HPRAC) to:

Recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges, beginning with the development of standards of practice and professional practice guidelines where regulated professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession.¹

In the course of preparing an interim report to the Minister, in conjunction with its review of the scope of practice of nurse practitioners, HPRAC and the Ministry determined that it was necessary to include scope of practice reviews of six professions – dietetics, midwifery, pharmacy, physiotherapy, medical laboratory technology and medical radiation technology – within the context of the advice that was requested regarding interprofessional collaboration. Advice on the first four of these professions was requested by August 31, 2008.

The scope of practice reviews have been carried out in response to the Minister's request for advice on collaboration between colleges to optimize professional scopes of practice for specific regulated health professionals as a mechanism to enhance quality of care and strengthen the opportunities for interprofessional collaboration at the clinical level. In Ontario, the legislative framework that defines health professions' scope of practice includes the *Regulated Health Professions Act, 1991 (RHPA)* and a series of profession-specific Acts. The *RHPA* contains provisions with respect to the duties and powers of the Minister, the role of HPRAC, a list of controlled acts and other statutory requirements. It also includes a procedural code governing the operation of regulatory colleges.

Each profession-specific Act includes a scope of practice statement. The scope of practice statement in the *Midwifery Act, 1991* states that²:

The practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.

The scope of practice statement found in each health profession act provides a generic frame of reference (or parameters) for the practice of each regulated health profession. A regulated health professional may perform his or her profession's authorized acts only in the course of practising within the profession's scope of practice. However, this statutory scope of practice statement is only one element of a profession's scope of practice. Each profession-specific Act also indicates any controlled acts the profession is authorized to perform, the title or titles restricted to members of the profession and other provisions.

Accordingly, as part of its review of professional scope of practice HPRAC³:

¹ Letter from the Minister of Health and Long-Term Care to HPRAC. June 2007.

http://www.hprac.org/en/reports/resources/HPRACletterJune28_2007.pdf

² *Midwifery Act, 1991*. http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91m31_e.htm

- analyzes the scope of practice statement and the controlled acts authorized to the profession;
- considers the implications of the harm clause contained in the *RHPA* (which prohibits everyone except health professionals acting within their scope of practice from treating or giving advice with respect to health where serious physical harm may result);⁴
- considers regulations developed under the profession-specific Act and other legislation that may affect the profession; and
- reviews the standards of practice, guidelines, policies and bylaws developed by the regulatory college.

Collectively, these elements determine the profession's scope of practice and therefore have been considered by HPRAC in its review of the scope of practice for midwifery.

The profession of midwifery was invited to submit recommendations articulating proposed changes required to their scope of practice to enhance interprofessional collaboration and assist members in working to the maximum of their scope of practice. The College of Midwives of Ontario (CMO), in collaboration with the Association of Ontario Midwives (AOM), submitted its response to HPRAC's *Applicant Questionnaire* respecting the scope of practice review for Midwifery in June 2008. The submission is available on HPRAC's website.⁵

In addition to requesting access to additional controlled acts, the College of Midwives of Ontario and the Association of Ontario Midwives propose to amend to the profession's scope of practice statement as follows⁶:

The practice of midwifery is:

- i. *The assessment and monitoring of the health of a woman and her baby during the normal course of pregnancy, labour and the postpartum period;*
- ii. *The provision of care related to the normal course of pregnancy, labour, and the postpartum period, including counselling, support and advice;*
- iii. *The management of vaginal deliveries.*

HPRAC has established 10 criteria that it considers in reviewing a profession's scope of practice.⁷

Purpose, Approach & Format of the Paper

This paper summarizes some of the recent literature on Midwifery practice as it relates to the changes being proposed. It is not intended to represent an exhaustive review of the literature;

³ See criteria. Review of a Professional Scope of Practice under the *Regulated Health Professions Act*. Health Professions Regulatory Advisory Council. May 2007.

http://www.hprac.org/en/reports/resources/Scope_of_Practice_June_12_2007.pdf

⁴ s.30 Effective June 4, 2009, or on an earlier day to be established by proclamation, this section will be amended by striking out "physical" and substituting "bodily". See *Health System Improvements Act, 2007*, S.O. 2007, c.10, Sched.M, ss.6 and 75 (1).

⁵ http://www.hprac.org/en/projects/Midwifery_Scope_of_Practice.asp

⁶ Supplemental summary chart to The College of Midwives of Ontario Submission to the Health Professions Regulatory Advisory Council. May 30, 2008.

<http://www.hprac.org/en/projects/resources/CollegeofMidwivesofOntarioSubmission.pdf>

⁷ See Review of a Professional Scope of Practice under the *Regulated Health Professions Act*.

http://www.hprac.org/en/reports/resources/Scope_of_Practice_June_12_2007.pdf

rather, it focuses on identifying key documents that may help to inform discussions about and considerations of the scope of practice review for Midwifery in Ontario.

This review is being undertaken in the context of a broader review requested by the Minister of Health and Long-Term Care to explore opportunities to advance interprofessional collaboration across regulated health professions. It includes a review of scopes of practice for a number of health professions that are most directly involved in interprofessional care to ensure that there are no legislative, regulatory, structural or process barriers to members of the professions working to the maximum of their scope of practice or to working in interprofessional settings or collaborative teams.

As such, it is recommended that this literature review be examined in conjunction with an earlier literature review⁸ completed by HPRAC in January 2008. That review looked at interprofessional collaboration with respect to the legislative, regulatory, policy and structural/organizational issues that can facilitate and support health regulatory colleges and their members in advancing collaborative practice.

The literature included in the midwifery review comes from diverse sources. Initial reference documents were included in the submissions to HPRAC by *The College of Midwives of Ontario* (May 30, 2008)⁹. Additional literature sources were identified through a literature search focused on the following terms: “scope of practice midwifery” - “scope of practice midwives” - “midwifery and scope of practice” - “enhanced scope of practice for midwives” – “midwives Ontario”. The review included a review of regulatory-related articles using *PubMedline Search*. In addition, supplementary searches were undertaken to identify specific articles from government websites, midwifery associations, and health policy think tanks in an attempt to locate studies related to regulation and midwifery scope of practice as identified in some of the literature reviewed. Some of these searches were successful, others were not.

The literature reviewed on the issue has been organized as follows:

- Section 1 provides an overview of two seminal reports on midwifery that have been published in recent years. These reports include: the Multidisciplinary Primary Maternity Care Project (“MCP²”), funded by Health Canada through the Primary Health Care Transition Funds Program and the Ontario Maternity Care Expert Panel (“OMCEP”) funded by the Ontario Women’s Health Council.
- Section 2 provides a high level analysis summarizing some of the key findings arising from the literature included in this review.
- Section 3 summarizes the documents reviewed organized under the following broad themes: scope of practice; health system needs/ improvement; and health outcomes/patient safety/ risk of harm

⁸ See www.hprac.org for the full copy of the literature review: HPRAC. Interprofessional Regulatory Collaboration – A summary of key reference documents and selected highlights from the literature. January 2008.

⁹ The Midwifery Scope of Practice Submission, The College of Midwives of Ontario Submission to the Health Professions Regulatory Advisory Council, May 30, 2008.

Section 1: Overview of Seminal Reports

Multidisciplinary Collaborative Primary Maternity Care Project (MCP²)

The ***Multidisciplinary Collaborative Primary Maternity Care Project (MCP²)*** was designed to address the human resource shortage crisis that exists in the provision of intrapartum care to pregnant women. The goal of the project was to reduce barriers and facilitate the implementation of national multidisciplinary collaborative primary maternity care strategies as a means of increasing the availability and quality of maternity services for all Canadian women.

Associations representing the full range of maternity care providers in Canada worked collaboratively¹⁰ to develop the initiative based on the following shared mission: to collectively champion changes to the provision of maternity services and to shift the current model toward more collaborative models of primary maternity care.

The core components arising from the MCP² project included:

- Guidelines for Models;
- National Standards for Terminology and Scopes of Practice;
- Harmonization of Standards and Legislation for Recommendations on the continuing development of a pan-Canadian approach to services, resources and strategies;
- Collaboration among Professionals;
- Changing Practice Patterns;
- Facilitating Information Sharing and Promoting the Benefits of Multidisciplinary Collaborative Maternity Care.

The final report of the MCP² project was published in 2006 and built on findings arising from five research papers, a Harmonization Working Group on standards and legislation, consultation and working groups on increasing collaboration through the National Primary Maternity Care Committee, focus groups and a public communications plan. The report is considered a seminal piece of work guiding future changes with respect to national multidisciplinary collaborative primary maternity care strategies.

MCP² Final Report Recommendations

- Develop a coordinated, pan-Canadian approach to multidisciplinary collaborative maternal/newborn care services that respect the diversities and realities of each province and territory.
- Advocate, at a pan-Canadian level, for the resources required to support the appropriate delivery of multidisciplinary collaborative maternal/newborn care services in each jurisdiction.
- Seek consensus for key strategies that will establish, retain or expand multidisciplinary collaborative maternity services.
- Establish a *National Multidisciplinary Collaborative Primary Maternity Care Committee* as an advisory body to governments and other key stakeholders.
- Develop models of multidisciplinary collaborative primary maternal/newborn care developed with teams in rural, remote and urban locations.

¹⁰ The partner organizations included: the Association of Women's Health, Obstetric and Neonatal Nurses Canada (AWHONN Canada), the Canadian Association of Midwives (CAM), the College of Family Physicians of Canada (CFPC), the Society of Obstetricians and Gynecologists of Canada (SOGC), the Society of Rural Physicians of Canada (SRPC), and the Canadian Nurses Association (CNA).

- Recognize the unique value and importance of each professional provider, federal/ provincial/ territorial governments and health authorities ensure that women and newborns have opportunities to access all appropriate maternal/newborn care services.
- Ensure regulators and legislators work collaboratively with maternal/newborn care providers to develop regulations and legislation that allow collaborative maternal/newborn care practice to work effectively.
- Ensure that information related to multidisciplinary collaborative maternal/newborn care is effectively communicated and readily available to all providers and consumers.

Key Findings of Multidisciplinary Collaborative Primary Maternity Care Project Background Research – Final Report¹¹

- Midwifery is a relatively new profession in Canada, although internationally, midwives are well-recognized and fully integrated into health care systems.
- Midwives are the only health care professional specifically educated to provide care for women expecting spontaneous, normal pregnancies and births, and expecting healthy babies. Midwives are also the only profession to offer choice of birth place (in both the home and at a hospital).
- With fewer family physicians and obstetricians providing obstetrical care, midwives could effectively fill the gap left in providing care to women with low risk pregnancies and birth. Achieving this goal will require new policies, including increased funding commitments at the provincial and federal levels to enhance the capacity of the midwifery profession to help solve the practitioner shortage.
- Midwifery roles are gradually evolving. An expanded scope of practice would allow midwives to safely and effectively meet the needs of a larger portion of the low-risk childbearing population. Expanding midwives’ scope of practice would result in their full integration in maternity care services. This would help fill the gap in practitioner shortage, therefore enhancing the overall maternity care system and allow an efficient multidisciplinary collaborative primary maternity care model.

Collaborative Maternity Care Models	<i>Collaborative Primary Maternity Care Models</i>	<ul style="list-style-type: none"> • Multidisciplinary primary maternity care is identified as a means of sustaining and improving maternity care in Canada. • A number of barriers to multidisciplinary collaborative primary maternity care include: regulatory, scope of practice, financial/economic, medico-legal and liability, education, lack of awareness and infrastructure issues. • The term “collaboration” is not a part of the vocabulary of the legislation governing health care professionals and therefore not part of the culture. • The 2001 <i>Agreement on Mobility for Midwifery in Canada</i> is a first step toward greater collaboration in the midwifery profession, particularly given that the five jurisdictions that do not currently regulate the profession also signed the Agreement.
	<i>Current Collaborative</i>	<ul style="list-style-type: none"> • Ten collaborative care models were identified in Canada, in Alberta, British Columbia, Ontario and Quebec. These models represent a sample of the models currently functioning in Canada, and the next phase of the MCP² will

¹¹ Solugik Public Affairs. (2005) *Multidisciplinary Collaborative Primary Maternity Care Project Background Research – Final Report*. Key research paper in the MCP² project.

	<i>Primary Maternity Care Models</i>	<p>focus on a more extensive search and description of collaborative maternity care models.</p> <ul style="list-style-type: none"> • Of the ten identified models, four are specifically oriented towards primary maternity care.
Provincial and Territorial Legislative Overview	<i>Legislative Overview</i>	<ul style="list-style-type: none"> • All jurisdictions have a significant regulatory framework for health care professionals; however there is a great deal of inconsistency and a number of gaps. • Ontario is the only jurisdiction with an overarching act (<i>Regulated Health Professionals Act</i>) which applies to all health care professionals. • All jurisdictions regulate family physicians and registered nurses while some jurisdictions do not recognize or regulate nurse practitioners or midwives. • The legislated requirement for liability insurance varies across all jurisdictions. • There is minimal information on educational requirements for health care professionals. • All jurisdictions make specific references to Aboriginal midwives; however there are no other references to Aboriginals within other legislation.
	<i>Scope of Practice</i>	<ul style="list-style-type: none"> • Scopes of practice vary significantly across all health care professions and across all jurisdictions in Canada as health care are exclusive of a provincial jurisdiction. • In some cases, scopes of practice are described in the governing legislation. In many instances detailed description of scopes of practice are left to the regulatory and/or professional associations. • Several organizations have attempted to define scope of practice. The Canadian Medical Association (CMA), Canadian Nurses Association (CNA) and Canadian Pharmacists Association (CPhA) have identified principles to be followed when describing scope of practice including focus, flexibility, coordination and patient choice. • CMA, CNA and CPhA also identified criterion to be used in developing scope of practice including accountability, education, competencies and practice standards, quality assurance and improvement, risk assessment, evidence-based practices, setting and culture, legal liability and insurance, and regulation. • Four factors have been identified that influence scope of practice: the evolution of professions, continual introduction of technology and acceptance of complementary therapies, level of education and issues of overlap and shared practice.
Comparative Analysis of Scope of Practice	<i>Legislation</i>	<ul style="list-style-type: none"> • Legislation governing the medical profession tends to be the least comprehensive across Canada and is often silent on scope of practice. • Midwifery tends to be the most descriptive in their scope of practice, likely because of the youth of the profession.
	<i>Regulatory Colleges and Associations</i>	<ul style="list-style-type: none"> • There is little description of scope of practice governing the medical profession or professional. • For nursing, description of scope of practice can be found in eight jurisdictions. The five jurisdictions that have active midwifery legislation do

		not have descriptions of scope of practice from their respective regulatory bodies/associations; however their respective midwifery legislation contains considerably detailed descriptions of scope of practice compared to other health professions.
	Classification of Scopes of Practices (Legislation and Regulatory Colleges/Associations)	<ul style="list-style-type: none"> • Four classification criteria emerged from the examination of scope of practice in both legislation and regulatory colleges/associations: <ul style="list-style-type: none"> ▪ A general description ▪ A technical description ▪ Authorized practice ▪ Limitation of practice
Terminology		<ul style="list-style-type: none"> • The first step toward developing an analytical framework for terminology is to select three variables to analyze: stage of motherhood, the maternity services required and the care provider. • Matching the stages of motherhood to maternity services required allows us to arrive at the continuum of care from the mother's perspective. From that point, the care provider variable is introduced. • There are considerable overlaps in maternity care services that can be delivered by various care providers. • Shared competencies amongst all care providers extend through the stage of pregnancy. • Maternity services are offered by the largest range of care providers in the post-partum period with the exception of OB/GYN who in many cases is no longer involved.

Maternity Care Models Currently Used in Europe and Australia¹²

Country	Target Population	Antenatal	Intrapartum	Post Natal	Continuity of Care ¹³
Netherlands	Low-risk pregnancies	Independent midwife	Independent midwife	Independent midwife, maternity home care assistant	Yes
	High-risk pregnancies	Referred from independent midwife to Obstetrician (and midwives) in hospital	Obstetrician (and midwives) in hospital	Obstetricians and nurses in hospital, independent midwife and maternity home care assistant at home	Partly
United Kingdom	Low-risk pregnancies	Community midwife or midwives in hospital	Midwives in hospital	Midwives in hospital and community midwives at home	Partly

¹² Herschderfer, K. and Haneke, K. (2005) *Current Practice in Europe and Australia: A Descriptive Study*. Background Research Paper, MCP2.

¹³ Continuity of care refers to continuity in the type of care provided with respect to the model of care delivery, not necessarily continuity in care provider.

	High-risk pregnancies	Obstetricians and midwives in hospital	Hospital obstetricians and midwives	Midwives and hospital and community midwives at home	No
Sweden	Low-risk pregnancies	Midwife in maternity care centre	Midwives in hospital	Midwife in maternity clinic	Partly
	High-risk pregnancies	Obstetricians and midwives in hospital	Midwives, obstetricians in case of instrumental delivery or CS	Midwives in hospital and midwives of the maternity clinic at home	No
Germany	Low-risk pregnancies	Private practice obstetrician and/or sometimes independent midwife	Hospital midwives and obstetricians or midwives or obstetrician with hospital privileges	Hospital midwives or midwives with hospital privileges (if necessary also obstetrician) and independent midwives at home	No
	High-risk pregnancies	Gynaecologist and sometimes midwife in private practice or in hospital	Midwives in hospital, obstetrician almost always attend the birth	Midwives and obstetrician in hospital, independent midwives at home	No
France	All pregnancies	Midwife and/or medical gynaecologist and/or gynaecologist-obstetrician and/or GPs	Midwives and gynaecologist-obstetricians in hospital	Independent midwife or hospital based midwife, at home	No
Australia ¹⁴	All pregnancies	Midwife and/or obstetricians and/or GP	Midwives and obstetrician in hospital	Midwives in hospital and independent midwives or midwives employed by the hospital, at home	Partly

Final Report of the Ontario Maternity Care Expert Panel (OMCEP): Emerging Crisis, Emerging Solutions (2006)

¹⁴ Australia was added because of the important role played by General Practitioners in models of maternity care in that country.

In October 2004, the Ontario Women's Health Council (OWHC) appointed the Ontario Maternity Care Expert Panel (OMCEP) to examine and make recommendations on an improved maternity care system in Ontario. The OMCEP's review and the preparation of its final report (2006) coincided with policy developments in primary health care transformation, a new vision of government stewardship and the introduction of Local Integrated Health Networks (LHINs).

Recommendations in the final OMCEP report are premised on the need for a fundamental shift in maternity care including:

- the organization of maternity care that involves the full range of health care providers (including family physicians, nurses, midwives and obstetricians), programs and ministries;
- integration of services so that women and newborns receive primary health care services (including birth services) close to home and acute and complex care in a timely and coordinated way; and
- a provincial strategy that integrates maternity care activities so that changes in one area do not indirectly result in negative effects in other areas.

Key Findings

The conclusion arising from the OMCEP study is that maternity care in Ontario faces an emerging crisis being fuelled by the following trends:

- A professional pool of care providers and institutions that are stretched beyond their capacity.
- A growing number of communities' do not having adequate birthing services to provide even basic obstetrical care. This shortage has arisen in direct response to a dramatic withdrawal of family physicians providing obstetrical services and a shortage of experienced nurses.
- Rising rates of intervention including labour induction, forceps and C-section deliveries contributing to increased hospital stays and costs of maternity care to the overall health system.
- Increased pressures for small/medium-sized urban settings and rural communities to withdraw from providing maternity care services.

Highlights of Recommendations throughout Report Focusing on Midwifery:

- Midwifery program entrant class sizes should be expanded to increase to the proportion of births attended by midwives in Ontario and address the unmet demand for services.
- There is a particular need for education about the scopes of practice and roles of midwives and nurse practitioners and about interprofessional models of care at the undergraduate, postgraduate and continuing education levels.
- Models of care that include midwives and interprofessional groups must be flexible enough to recognize the choices that families may make in their care and recognize care providers' different roles, scopes and competencies.
- In rural settings there are modifications to the scope of practice for all professionals; in these settings, midwives and nurses also acquire skills and play the roles that are needed to meet community needs. These rural models typically have low volumes and require practitioners who are committed to careful risk screening of women and newborns and planning for the small proportion of families whose births may not be suitable to take place in rural and remote places.
- There are problems with the governance system to permit physicians and registered midwives to obtain admitting and discharge privileges in acute care hospitals through the Public Hospitals Act. OMCEP recommends that hospitals use the College of Midwives of Ontario standard *Indications for Mandatory Discussion, Consultation and Transfer of Care 24* as the basis for local consultation and transfer of care protocols.

- The Ministry of Health and Long-Term Care and regulatory colleges should consider expanded roles for nurses and midwives working in “special” environments to deliver care closest to home and in a culturally sensitive manner. This might include first assist for Caesarean section in rural and under-serviced areas, use of vacuum-assisted birth in urgent situations and repair of third or fourth degree perineal tears for midwives where specialist care is not available.

OMCEP Final Report Recommendations

- Increase the number of maternity care providers and declare a moratorium on maternity care program closures in communities that have sufficient health human resources to maintain safe services.
- Establish an ongoing provincial maternity care program led by MOHLTC and regional networks of care providers to be responsible for: creation of a sustainable maternal and newborn care plan for Ontario with full financial responsibility and accountability; integration of that plan across ministries, all regions and services; alignment of the maternity care plan with the government’s transformation plan with maternity care as an integral part of primary care; ongoing performance measurement to ensure access to quality & services.
- Incorporate women’s input into maternity care at all levels from informed decision-making about their own care to local, regional and provincial service planning policy.
- Ensure timely and equitable access to quality maternity care by committing to: primary maternity care delivered close to home; services that are responsive to the needs of diverse and vulnerable populations; woman and family-centred models of care; and regionally coordinated access to high -risk care.
- Create and undertake public and professional education campaigns to support a sustainable maternity care system and promote pregnancy and birth as a normal physiologic process with access to care for complications, as needed.
- Attract, support and retain maternity care providers by developing a system that values and respects all provider groups, including midwives, nurses and physicians through harmonization of regulation and liability mechanisms and creation of complementary funding schemes.
- Remove barriers to care and create structures that support: the effective use of all care providers to their full scopes of practice; collaboration among professionals; innovative interprofessional models of education and clinical care founded on evidence-based guidelines and practices

Section 2: Highlights & Analysis of Key Findings from the Literature

Following are some of the key findings arising from key references that were reviewed as part of this project. It is important to note that the synthesis that follows needs to be considered in the context of the limitations associated with the review namely, the paucity of literature available related specifically to the issue of scope of practice/ enhanced scope of practice for Midwifery.

- ***Primary maternity health care reform in Canada is being driven by several initiatives including the Government of Canada's Primary Health Care Transition Funds (PHCTF), the Commission on the Future of Health Care in Canada ('Romanow Report'), the work of The Multidisciplinary Collaborative Primary Maternity Care Project (funded by PHCTF) as well as changing characteristics and trends in maternity care delivery.***
- ***In recent years, the concept of "multidisciplinary collaborative primary maternity care" has been identified as a means of sustaining and improving maternity care in Canada.*** The literature supports concerns related to the sustainability of the maternity care system and the need for the implementation of multi-dimensional and multi-jurisdictional solutions in Canada to address the following trends: demographic and societal changes; increase in the number of babies requiring medical attention in intensive care units; human resource shortages among maternity care providers; and, regional disparities in the provision of maternity care services. These trends call for the development of new policies at the federal and provincial levels to enhance the capacity of midwifery to make a greater contribution to maternity care and to help solve the practitioner shortage.
- ***Key barriers prohibiting faster implementation of multidisciplinary collaborative primary maternity care include regulatory, scope of practice, financial/economic, medico-legal and liability, education, lack of awareness and infrastructure issues.***
- ***The submission by The College of Midwives of Ontario (May 2008) to the Health Professions Regulatory Advisory Council (HPRAC) provides the most focused discussion of issues related to scope of practice including the rationale, potential benefits, and details outlining the proposed changes and additions being proposed for expanding the scope of practice for midwives in Ontario.***
- ***Ontario was the first Canadian jurisdiction to regulate the profession of midwifery. Ontario's model of midwifery embodies the principle of informed choice and recognizes the client as the primary decision-maker. Accordingly, midwives have a different philosophy of care, a different funding model, a different organizational style (e.g., practice groups), etc.***
- ***Current efforts across Canada and in other jurisdictions are focused on addressing a number of shortcomings in the scope of practice to reflect current community standards and needs, ensure continued public safety, and further enhance and enable collaboration between providers to ensure that clients continue to have access to continuity of care.*** Although midwives have been fully integrated into the health care system across Canada and are seen as an integral part of the primary care system for low risk normal pregnancies and birth, collaborative efforts of physicians and midwives in the community are needed to ensure long-term delivery of high quality care to Canadian women.
- ***Current challenges restricting full integration and participation of midwives in the delivery of care include:***

- Limited access to care (i.e., regional inequalities, human resource shortages, rural/urban inequalities, and inequity in Aboriginal communities)
 - Funding mechanisms for both midwives and physicians
 - Hospital credentialing process and restrictive local protocols
 - Provincial process for amending regulations
 - Inflexibility in practice, scope of practice limits
 - Obstacles to Interprofessional Collaboration Among Maternity Care Providers (i.e., lack of a collaborative curriculum, limited interdisciplinary models of care).
- ***Despite stated commitments to evidence-based practice and adoption of common clinical guidelines, practice patterns among midwives vary significantly with significant variations found across settings.*** The integration of midwifery into hospitals has been inconsistent; there is significant variation within and across provinces.
 - ***All midwives must determine an acceptable and appropriate “scope of practice” in which to provide care that is safe, competent, and congruent with standards and models of care developed by Associations/ Colleges.*** There is a need for practitioners and educators to find common ground to combine evidence-based theory with evidence-based practice.
 - ***There is some literature supporting the role of midwifery in:***
 - ***Contributing to reducing the demand for hospital services and decreasing health care costs,***
 - ***Providing choices for women***
 - ***Providing prenatal care and delivery to low-risk maternity patients, with neonatal outcomes comparable to those of physician patients***
 - ***Allowing physicians to focus on high-risk pregnancies and emergency care.***
 - ***Models of care are significantly different in obstetric-led units compared with midwife-led units, leading to greater likelihood of intrapartum intervention, need for analgesia, and assisted or operative delivery.*** There is also some evidence supporting good/comparable clinical outcomes, safe practice and high rates of satisfaction among midwifery clients. In particular, findings from published research studies reviewed as part of this literature review observed:
 - Mothers in midwife-led units spent shorter times in labour in the unit, received less analgesia, had fewer interventions and were more likely to have a normal delivery than women in obstetric-led units.
 - Consistency in the generally favourable results of maternal and neonatal outcomes, both over time and among diverse population groups. These outcomes are also favourable when viewed in comparison to various reference groups (birth centre births, planned hospital births and vital statistics).
 - Similar outcomes arising from a comparison of home births with hospital births attended by a midwife. There was no increased maternal or neonatal risk associated with planned home birth under the care of a regulated midwife.
 - Women giving birth at home attended by a midwife having fewer procedures during labour than those giving birth in a hospital attended by a physician. They were less likely to have epidural analgesia, be induced, have their labour augmented with oxytocin or prostaglandins, or have an episiotomy.
 - Midwifery clients reporting greater satisfaction and a more positive attitude toward their childbirth experience than women in the care of physicians.
 - ***If midwifery is to survive and fulfill its commitment to women and families, the profession must:***

- Commit to supporting research designed to generate evidence that corroborates the strength of the profession.
- Work with their professional organizations to expand their legal status and role.
- Expand their own scope of practice by continually developing their primary care knowledge and skills.
- Undertake future research and studies in key areas including ongoing evaluation of home births, and additional work to define midwifery as distinct from medicine where both coexist within a collaborative system.

Section 3: Summary of the Literature

Scope of Practice

Authors, Title and Publication	Context/Type of Document	Main Findings/Recommendations
Alexander, J., Anderson, T. and Cunningham, S. An Evaluation by Focus Group and Survey of a Course for Midwifery Ventouse Practitioners. <i>Midwifery</i> . Vol 18 : 165-172. 2002.	<p>Evaluation of the Midwifery Ventouse Practitioners' (MVPs) Course and the MVP's perception of its effect on their practice. Focus group: n=8 ; Postal questionnaire: n=18</p> <p>18 midwives who had completed the MVP course at Bournemouth University between 1998 and 2000 participated. The protocol for facilitating ventouse birth was written by midwives themselves; it is a live document that continues to adapt to practice.</p> <p>An assisted birth using ventouse entails attaching a cup with a small vacuum pump to the baby's head to pull the baby out.</p>	<p>15 of 18 midwives felt that becoming an MVP had affected their overall practice by giving them more confidence in their practice.</p> <p>Ambulance transfer in the second stage was prevented for at least 109 women.</p> <p><u>Limitations:</u> Insufficient data for undertaking long-term clinical evaluation of the births to which an MVP has participated; Questionnaire did not ask the number of occasions that midwives declined to apply the ventouse as the protocol criteria were not met.</p>
American College of Nurse Midwives. Core Competencies for Basic Midwifery Practice. June 2007.	<p>Describes the fundamental knowledge, skills and behaviours expected of a new practitioner. The document serves as guidelines for educators, students, health care professionals, consumers, employers and policy makers; it constitutes the basic requisites for graduates of all nurse-midwifery and midwifery education programs accredited/preaccredited by the American College of Nurse-Midwives (ACNM) Division of Accreditation.</p>	<p>Includes the hallmarks of midwifery, professional responsibilities of certified nurse-midwives (CNM) and certified midwives (CM), midwifery management process, fundamentals of midwifery care, primary health care of women, management of common health problems, management of newborn care until 28 days of life.</p>
Association of Ontario Midwives. Midwives and Interprofessional Care. June 2008. www.aom.on.ca	<p>Position paper outlining the Association of Ontario Midwives' (AOM) support regarding inter-professional care (IPC) in the provision of maternity care in Ontario.</p> <p>The critical foundational</p>	<p>The AOM supports IPC initiatives and recognizes the potential of IPC initiatives to meet the needs of diverse communities. IPC initiatives hold the potential of addressing current and looming gaps in care and of keeping maternity care as close to home as possible.</p> <p><u>Recommendations</u></p> <ul style="list-style-type: none"> • MOHLTC provide specific funds to support IPC

Authors, Title and Publication	Context/Type of Document	Main Findings/Recommendations
	<p>elements (informed by the MCP2 and OMCEP reports) for successful IPC initiatives include:</p> <ul style="list-style-type: none"> • Recognizing collaboration is an essential precondition for successful IPC. • Visionary approaches to IPC that include midwives as team leaders. • Ensuring IPC teams are well planned, structured, funded and integrated into the communities they serve. • Understanding significant barriers to IPC exist in current legislation, including the <i>Public Hospitals Act</i>, but that not all regulation is a barrier. The road to effective IPC is through the strengths and opportunities available within professional self-regulation. However, regulation must keep pace with changes in clinical practice. For example, enabling midwives to order appropriate diagnostic testing for conditions within their scope of practice enables midwives to respond to client needs as primary providers within a team setting. • Enabling multiple and flexible IPC models that reflect the specific needs of individual communities. • Addressing funding barriers to IPC. Ontario midwives support the quality of care facilitated by the current model of practice which is enabled by course of care funding. Additional funding models and mechanisms are needed that enable IPC. • Valuing interprofessional education and ensuring providers encounter midwives working to the broadest possible scope. • Recognizing that increased collaboration between providers leads to improved risk management by enhancing the familiarity, understanding and comfort with the scope of practice of providers from various 	<p>pilot projects in communities that possess both the need and the providers willing to participate. Pilot projects will enable thorough evaluation and relevant “lessons learned” for subsequent initiatives.</p> <ul style="list-style-type: none"> • MOHLTC update the <i>Public Hospitals Act</i> to ensure midwives are guaranteed due process and right of appeal concerning hospital credentialing and representation on committees that determine credentialing. • MOHLTC direct LHINs to establish consistent guidelines for the integration of midwives into all hospitals that offer maternity care, including guidelines for credentialing and guidelines that ensure midwives are able to work to their fullest scope possible. Midwives must be able to work to their full scope in order to be fully integrated into hospitals and to fully participate in IPC models. Direct LHINs to offer incentives to hospitals that fully integrate midwives. • MOHLTC create funding mechanisms for compensating midwives involved in IPC models that are equitable both within new IPC models and also with midwives working in the current Ontario model. Adequately compensate obstetricians to provide on-call back-up for consultations and referrals from midwives. Physicians must be compensated to be available for high-risk transfers of care. Likewise, other specialists such as paediatricians or anaesthetists need to be compensated for direct referrals from midwives. • MOHLTC, in conjunction with the Ministry of Training, Colleges and Universities, earmark funds to enhance interprofessional education within the Midwifery Education Program (MEP) for midwifery students, medical students, residents, nursing students and other health care providers. The MEP, at each of its three sites at Ryerson, McMaster and Laurentian is an ideal group to provide interprofessional education with a specific focus on maternity care. • MOHLTC fund birth centres for low-risk normal birth and as model sites of interprofessional education and practice. Interprofessional education is essential to the success of IPC and birth centres offer an ideal environment for providers to learn from, with and about each other.

Authors, Title and Publication	Context/Type of Document	Main Findings/Recommendations
	professions.	
Bourgeault, I., Luce, J. & MacDonald, M. The Caring Dilemma in Midwifery. <i>Community, Work and Family</i> , Vol. 9, No. 4 (2006): 389-406.	Discusses the tension caused by being obliged to provide care without the right to determine how that care is provided. The paper traces both the structural and experiential aspects of the 'caring dilemma' through an examination of midwifery in Ontario.	This model involves the provision of care by a single and/or pair of midwives to a woman throughout her pregnancy (birth and post-natal period). Continuity of care necessitates that midwives be on-call for significant lengths of time to ensure attendance at the woman's birth. It is the on-call nature of this form of midwifery work that most significantly poses a caring dilemma for midwives. Despite being a salient feature of midwifery practice, some work structures can be created to mediate the caring dilemma experienced by midwives, such as autonomy in determining how care is to be provided.
Canadian Midwifery Regulators Consortium. Canadian Competencies for Midwives.	Outlines the knowledge and skills expected of an entry-level midwife in Canada. Provides a base for the development of national assessment processes and provides information to internationally educated midwives about the expectations of Canadian midwifery competencies.	Outlines general and specific competencies, including education and counselling, antepartum, intrapartum and postpartum care, care of the newborn and young infant and professional, interprofessional and legal aspects of the profession. Also outlines advanced competencies.
Carr, C. and Schott, A. Differences in Evidence-Based Care in Midwifery Practice and Education. <i>Journal of Nursing Scholarship</i> . Vol 43 (2) : 153-158. Published online 23 April 2004.	Examines site-specific differences in managing labour exploring variations in intrapartum practice in the context of clinical midwifery education. Descriptive design based on secondary analysis of an existing data set collected to evaluate the intrapartum clinical experiences of nurse-midwifery students. The data set included 498 records collected by midwifery students at 23 sites (1995–1998). The unit of analysis was the intrapartum record.	Despite a stated commitment to evidence-based practice and adoption of common clinical guidelines, practice patterns varied significantly with significant variations found across settings. Discrepancies between theoretical preparation of students for clinical practice and the realities of clinical practice were noted. Clinicians and educators need to find common ground for combining evidence-based theory with evidence-based practice. <u>Limitations:</u> Definition of variables; Non-random selection of patients.
Goldsmith J. Nurse midwives encounter new roadblocks. <i>American Journal of Nursing</i> . 2004 Feb; 104(2):25-6.	The article focuses on the decision taken by two major teaching hospitals in the U.S. to reduce or place strict limitations on deliveries by certified nurse midwives (CNMs), ending nearly all CNM-attended births. Describes the experience arising from the decision made by the University of Chicago Hospitals advising its CNMs to practice as physician extenders and work in the outpatient medical clinics in obstetrics and gynaecology, or to go into business for themselves and secure their own malpractice insurance.	Contends that the hospital was forced to restructure their policy because of a significant (400%) increase in state malpractice insurance rates combined with a low volume of midwifery deliveries that made it difficult to continue to support the service. The American College of Nurse-Midwives claim that midwives' success is the root of the problem and that this success leads to negative attention from competitors.
Herschderfer, K. and	Reviews the collaborative models	- The concept and criteria for collaboration differs

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<p>Haneke, K. (2005) <i>Current Practice in Europe and Australia: A Descriptive Study.</i></p>	<p>of maternity care as documented in France, Germany, The Netherlands, Sweden, United Kingdom and Australia. The report describes the national framework for practice in each country, including legal and regulatory issues, scope of practice, standards and guidelines, documentation and information transfer, financial and economical issues, medicolegal and liability issues, professional education and the number of professionals. The most common current model of maternity care is also described, as are models of collaboration within and between professions.</p>	<p>considerably from country to country.</p> <ul style="list-style-type: none"> - Generally, midwives provide care to women with low-obstetrical risk, although the scope of practice of midwives varies considerably from country to country. Obstetricians are responsible for high-risk pregnancies, with less variation among them between countries. In some cases, general practitioners are responsible for some maternity care, especially in rural and remote areas. - Two issues may negatively affect collaboration: the difference in philosophy among maternity care providers and the difference in level of education of the various professionals with different backgrounds. - Models of care are often ‘tailor-made’ to fit existing systems and changing circumstances and often reflect historical and cultural changes over time. - Professions have historically and culturally become ingrained in the maternal newborn health systems, and these models may not be integrally or explicitly exported to other systems of care in Canada. Canada should look at the competencies of the professions studied and transpose them to existing professions in the Canadian health system.
<p>Kelleher, K. Collaborative Practice - Characteristics, Barriers, Benefits, and Implications for Midwifery. <i>Journal of Nurse-Midwifery</i>, 43(1), (1998): 8-11.</p>	<p>Analysis of collaborative medical practice and the implications for midwifery. Includes a discussion of how collaboration is defined by various organizations and how midwifery has set its standard for collaborative practice.</p>	<p>The overlap of nurse-midwifery practice with medicine has long required a need for collaboration with physicians. Additional work needs to be done to define midwifery as distinct from medicine, where both coexist within a collaborative system. Review of the literature suggests that the degree of collaboration between physicians and nurse clinicians is high within health care environments with the pressures of managed care and perceived loss of supervisory control by the medical profession; however, overlapping responsibilities can lead to increased competitiveness and threaten professional collaboration.</p>
<p>Kennedy et al. Developing Midwifery Knowledge: Setting a Research Agenda. <i>Journal of Midwifery & Women's Health</i>, 52(2), (2007): 95 – 97.</p>	<p>Commentary explores the need to address the implications arising from the following trends: increasing caesarean birth rate; decline of nurse-midwives certified by the American College of Nurse-Midwives.</p>	<p>If midwifery is to survive in the U.S. and fulfill its commitment to women and families, the profession must commit to supporting research designed to generate evidence that corroborates the strength of the profession.</p>
<p>Maternity Care Working Party. <i>Making normal birth a reality: Consensus statement from the Maternity Care Working Party.</i> Royal College of Midwives, Royal College of Obstetrics and Gynaecologists, the</p>	<p>Consensus statement calling for a standard definition for normal labour and birth to allow for a valid audit and comparison of normal birth rates.</p> <p>Members supporting the statement include:</p> <ul style="list-style-type: none"> - The Royal College of Midwives - The Royal College of 	<p>The Information Centre for the National Health Service in England has adopted a working definition for normal labour and birth referred to as “normal delivery”. The definition is based on a measurement of the process of labour not the outcomes: “Without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery.” The article provides a good context for understanding the issues surrounding “normal” birth.</p>

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National Health Childbirth Trust. United Kingdom. (2007).	Obstetricians and Gynaecologists - The National Childbirth Trust - Nursing and Midwifery Council - RCM Consultant Midwives Forum - The Association for Improvements in Maternity Services - Independent Midwives Association - Association of Radical Midwives - BirthChoiceUK	

<p>Nixon, A. and Power, C. Towards a Framework for Establishing Rigor in a Discourse Analysis of Midwifery Professionalization. <i>Nursing Inquiry</i> 2007. Vol 14 (1): 71-79.</p>	<p>Discusses the need for a framework to establish rigour in discourse analysis (DA) in nurse and midwifery research. Examines professional transition in midwifery in Australia.</p>	<p>Clarifying various positions in DA before data analysis is most useful. The paper proposes components that need to be considered for development of a rigorous framework including:</p> <ul style="list-style-type: none"> - Clear research question: is it appropriate for DA? - Clear definition of discourse and species of DA. - Effective use of theoretical framework – clarity and explicitness in epistemological and ontological positioning (parallel/replication perspectives) - Transparency in analysis methods and application of theory to the analysis. - Clarity in selection of talk/texts. - Concepts/criteria/strategies to guide analysis. <p>As nurses and midwives increasingly apply DA in their research, attempts to clarify how rigour will be determined are important if the outcomes of such research are to be seriously considered and translated into changes in theory, policy and practice.</p>
<p>Rosenblatt, R. et al. Professional Relationships between Midwives and Physicians: Collaboration or Conflict? <i>American Journal of Public Health</i>. Vol 82 (2): 262-264. February 1992.</p>	<p>Examines the professional relationships between midwives and physicians providing care in obstetrical care in Washington State.</p> <p>496 randomly sampled family physicians and obstetricians-gynaecologists and 211 certified nurses, licensed and lay midwives were surveyed to learn more about midwife/physician relationships.</p>	<p>Only certified nurse midwives have forged mutually satisfactory relationships with the physician community. Increased hospital-based training and practice opportunities are needed before licensed midwives can improve their professional relationships with physicians.</p>
<p>Schuling, K. & Slager, J. Scope of Practice: Freedom Within Limits. <i>Journal of Midwifery and Women's Health</i>, 45(6), (2000): 465-471.</p>	<p>Peer-reviewed journal article. Discusses “scope of practice” through a review of clinical scenarios as the basis for providing new and experienced midwives with a substantive definition of the concept “scope of practice.”</p>	<p>All midwives must determine an acceptable and appropriate “scope of practice” in which to provide care that is safe, competent, and congruent with the ACNM model of midwifery care. “Scope of practice” is determined by the inflexible boundaries and flexible clinical parameters as it is by the midwife’s own philosophy of care.</p>
<p>Society of Obstetricians and Gynaecologists of Canada. A Report on Best Practices for Returning Birth to Rural and Remote Aboriginal Communities. <i>Journal of Obstetrics and Gynaecology Canada</i>. No. 188, March 2007.</p>	<p>Policy Report on best practices reviewing policies currently in place in Aboriginal communities that recommend transfer of all pregnant women at 36 to 37 weeks’ gestation to a Level 2 hospital.</p>	<ul style="list-style-type: none"> - Physicians, nurses, hospital administrators, and funding agencies (both government and non-government) should ensure that they are well informed about the health needs of First Nations, Inuit, and Métis people and the broader determinants of health. - Aboriginal communities and health institutions must work together to change existing maternity programs. - Plans for maternal and child health care in Aboriginal communities should include a “healing map” that outlines the determinants of health. - Midwifery care and midwifery training should be an integral part of changes in maternity care for rural and remote Aboriginal communities. - Protocols for emergency and non-emergency clinical care in Aboriginal communities should be developed in conjunction with midwifery programs in those communities.

		<ul style="list-style-type: none"> - Midwives working in rural and remote communities should be seen as primary caregivers for all pregnant women in the community.
<p>Society of Obstetricians and Gynaecologists of Canada (SOGC). Midwifery. Journal of Obstetrics and Gynaecology. 2003; 25 (3): 239.</p>	<p>Policy Statement developed by the Executive Committee of (SOGC) and approved by its Council.</p> <p>SOGC supports the continuing process of establishing midwifery in Canada as a regulated, publicly funded profession with access to hospital privileges.</p> <p>SOGC proposes that midwifery education programs, leading to a diploma or degree, be undertaken and integrated with colleges or universities across Canada. The SOGC continues its support of ongoing evaluation and accreditation of midwifery programs.</p> <p>SOGC will extend membership to registered midwives and offer them access to ongoing educational experiences.</p> <p>SOGC recognizes and stresses the importance of choice for women and their families in the birthing process. SOGC recognizes that women will continue to choose the setting in which they will give birth. All women should receive information about the risks and benefits of their chosen place for giving birth, and should understand any identified limitation of care at their planned birth setting.</p> <p>SOGC endorses evidence-based practice and encourages ongoing research into the safe environment of all birth settings.</p>	<p>The SOGC supports integration of midwifery into the obstetrical health care team. SOGC is committed to the development and maintenance of excellent educational standards and mechanisms that bring midwifery into the existing health care structure.</p> <p>SOGC promotes the building of interprofessional relationships between midwives and other obstetrical care providers in the interests of providing excellent health care for women and their babies.</p> <p>SOGC believes midwives should be integrated members of the maternity care team in their community and hospital. Strategies to effect this integration should include:</p> <ul style="list-style-type: none"> ▪ Mechanisms to provide access to health care resources and facilities such as laboratory tests, ultrasound, and prescription medications. ▪ Development of policies and procedures to ensure smooth integration of patient care between midwives and other obstetrical care providers. ▪ Appropriate remuneration of consultation requests from midwives. ▪ Integration of outcome results (maternal and perinatal) into existing quality assurance programs and outcome statistics. ▪ Membership of midwives on committees concerned with maternal and newborn issues. ▪ Development of policies concerned with complaints and performance issues. ▪ Mechanisms for liaison between professional associations and regulating bodies of midwifery and other professional and regulatory bodies. ▪ Development of midwifery standards of care. ▪ Provision of appropriate malpractice coverage for midwives.
<p>Spiby, H. and Munro, J. The Development and Peer Review of Evidence-Based Guidelines to Support Midwifery Led Care in Labour. <i>Midwifery</i>. 2007 May 16 [epub ahead of print].</p>	<p>Commissioned by the Royal College of Midwives in the U.K, provides a description of the development and peer review process for the third edition of evidence-based guidelines to support midwifery-led care in labour.</p> <p>The development of the evidence-based guidelines is discussed in the context of the debate related to guideline development and evidence-based practice including</p>	<p>Clinical guidelines are a key component of clinical governance in the UK and evidence-based practice internationally. Guidelines therefore have the potential to influence midwives' practice significantly.</p> <p><u>Highlights:</u></p> <ul style="list-style-type: none"> - Guidelines require regular review to maintain their currency and to incorporate new evidence that becomes available. - The incorporation of expert opinion is a well-established feature of the guideline development process and may occur in a range of ways; this appears to offer challenges in the context of midwifery-related guidelines, as the role of consultant midwife is still relatively new and

	issues related to the nature and hierarchy of evidence, stakeholder involvement and sociological discourses of evidence-based medicine.	<p>midwives in diverse posts and roles.</p> <ul style="list-style-type: none"> - Further debate is required to explore the relative merits and contributions of unidisciplinary guidelines for topics such as midwifery-led care when national multi-disciplinary guidelines for intra-partum care will also soon be available; use of evidence hierarchies; how midwifery involvement in multidisciplinary guideline development can be fostered and supported in what can often be a hostile and medically dominated environment; how capacity can be developed in this important component of midwifery where concerns of academic rigour must be merged with clinical appropriateness and consideration of midwifery philosophies.
Sullivan, N. CNMs/CMs As Primary Care Providers: Scope of Practice Issues. <i>Journal of Midwifery and Women's Health</i> , 45(6), (2000): 450-456.	<p>Descriptive analysis of “primary care” and the boundaries of scope of practice for certified nurse-midwives/certified midwives.</p> <p>Article explores the history of primary care, reviews the most commonly accepted definition of primary care, discusses the boundaries of scope of practice in primary care, and the legal and economic ramifications of certified nurse-midwives/certified midwives practice in this area.</p>	Midwives are conflicted about their role in providing primary care services. Although most midwives perform some primary care services, there is no legal mandate for the designation of midwives as primary care providers in most states. Midwives who want to ensure their future as primary care providers should work with their professional organizations to expand the legal status and the role of the midwife, to market the primary care knowledge and skills of midwives to managed care organizations, and to expand their own scope of practice by continually developing their primary care knowledge and skills.
The College of Midwives of Ontario. The Midwifery Scope of Practice. Submission to the Health Professions Regulatory Advisory Council. May 30, 2008.	Submission to HPRAC by The College of Midwives of Ontario (CMO) in collaboration with the Association of Ontario Midwives (AOM) Submission.	<p>Current state of midwifery in Ontario is inadequate to meet the growing needs of women and families. Research undertaken by the CMO showed that 40% of women who wanted midwifery care in 2007/08 were unable to receive it.</p> <p>Submissions includes a discussion regarding the existing barriers to midwives practicing to their current legislated full scope of practice and the proposed expansions to midwives’ current legislated scope of practice. The proposed expansions to midwives’ scope of practice are separated into two areas:</p> <ol style="list-style-type: none"> i. Those changes that will be mandatory for all midwives to adopt as part of the scope of practice (routine scope); ii. Those changes that will be optional additions to a midwife’s scope (extended scope).
Van Wagner, V. et al. Reclaiming Birth, Health, and Community: Midwifery in the Inuit Villages of Nunavik, Canada. <i>Journal of Midwifery and Women's Health</i> . Vol 52 (4) July/August 2007.	<p>Descriptive article of the Inuulitsivik midwifery service and education program in Nunavik, Quebec.</p> <p>The Inuulitsivik Health Centre serves seven communities on the Hudson Bay and Hudson Strait coasts with a population of about 5500. Inuulitsivik encompasses a local health center in each community, often called “the nursing station”; a small, 25-bed general hospital in Puvirnitug; and a mental health center in Inukjuak. All of the communities</p>	<p>The service is seen as a model of community-based education of Aboriginal midwives, integrating both traditional and modern approaches to care and education. Developed in response to criticisms of the policy of evacuating women from the region in order to give birth in hospitals in southern Canada, the midwifery service is integrally linked to community development, cultural revival, and healing from the impacts of colonization. The midwifery-led collaborative model of care involves effective teamwork between midwives, physicians, and nurses working in the remote villages and at the regional and tertiary referral centers.</p> <p>Inuulitsivik midwifery shows that birth in remote communities far from tertiary care can be safe, and can</p>

	are remote fly-in villages, with transfer for tertiary care more than 1000 kilometres to the south, in Montreal.	<p>improve outcomes when compared with a policy of evacuation. It models sustainable and culturally- based local education in remote communities. Midwifery can contribute to maintaining meaning in cultures that are attempting to recover from the impacts of colonization and rapid change.</p> <p>The lesson that midwives have an important role to play in promoting health and well-being and in cultural revival in Canadian aboriginal communities has the potential to inform other settings.</p> <p>Strong community support and collaboration between midwives from very different backgrounds has been critical to the success of Inuulitsivik midwifery.</p>
Westfall R. The state of midwifery in British Columbia, Canada. <i>Midwifery Today - International Midwife</i> . 2002 Summer;(62):51-5.	Traces the origins and evolution of midwifery in British Columbia. Includes a discussion of the introduction of midwifery into practice in BC in 1998, covered under the Medical Services Plan.	Once legislated, the occupation of midwifery changed to appeal to a wider client base, to the general public, to other health care professionals and to the state. Today midwives work both in hospital and at home and under the standards and protocols of a regulatory body that is seen as hampering their ability to develop unique styles of work. Midwives and their clients need to challenge the regulatory body they themselves helped to create to ensure that the occupation of midwifery continues to meet their needs.

Health System Needs & Improvement

Authors, Title and Publication	Context/ Type of Document or Study	Main Findings/Recommendations
American College of Obstetricians and Gynaecologists. Immunization During Pregnancy. American College of Obstetricians and Gynaecologists Committee Opinion No. 282. <i>Obstetrics and Gynaecology</i> . 101: 207-212. 2003.	<p>Current recommendations for immunization of pregnant women, as determined by the American College of Obstetricians and Gynaecologists.</p> <p>Preconceptional immunization of pregnant women to prevent disease in the offspring, when practical, is preferred to vaccination of pregnant women. The benefits of immunization to the pregnant woman and her neonate usually outweigh the theoretic risks of adverse effects. Vaccination of women during the postpartum period, especially for rubella and varicella, should be encouraged.</p>	Recommended immunizations: Measles, Mumps, Poliomyelitis, Rubella, Yellow fever, Varicella, Influenza, Rabies, Hepatitis B, Hepatitis A, Pneumococcus, Meningococcus, Typhoid, Anthrax, Tetanus-diphtheria.

<p>British Columbia Centre of Excellence for Women's Health. Solving the Maternity Care Crisis: Making Way for Midwifery's Contribution. <i>Policy Series</i>. Vancouver, British Columbia, British Columbia Centre of Excellence for Women's Health.</p>	<p>Policy/Research Paper. The attrition rate for physicians providing maternity care is high. Attracting new practitioners to the specialty is becoming increasingly difficult because of its demanding lifestyle, practitioners' fears about litigation, and inadequate pay. Less than half of the family physicians in Canada offer maternity care to their patients.</p>	<p>New policies are needed at the federal and provincial levels to enhance the capacity of midwifery to make a greater contribution to maternity care and to help solve the practitioner shortage.</p> <p>Current challenges that restrict midwifery include:</p> <ul style="list-style-type: none"> - Limited access to care (i.e., regional inequalities, human resource shortages, rural/urban inequalities, and inequity in Aboriginal communities). - Conditions that threaten the sustainability of midwifery (i.e., inadequate remuneration, inflexibility in practice, scope of practice limits). - Obstacles to Interprofessional Collaboration Among Maternity Care Providers (i.e., lack of a collaborative curriculum, limited interdisciplinary models of care).
<p>Cameron, H. Modern Midwifery in Ontario: An Effective Model of Health Care. <i>University of Toronto Medical Journal</i>, Vol. 82, 3 (2005): 207-209.</p>	<p>Descriptive article reviewing the history of midwifery in Ontario, the tenets of midwifery care and the future of midwifery in the province. Since being regulated in 1993, midwifery is a growing profession with increasing demand for service in the community.</p>	<p>The principles of midwifery care are continuity of care, informed choice and choice of birthplace. The midwifery model of care contributes to reducing the demand for hospital services and decreasing health care costs, provides choices for women, and allows physicians to focus on high-risk pregnancies and emergency care. Concludes that collaborative efforts of physicians and midwives in the community will help to ensure long-term delivery of high quality care to Canadian women.</p>
<p>Fullerton, J. et al. Outcomes of Planned Home Birth: An Integrative Review. <i>Journal of Midwifery and Women's Health</i>. Vol 52 (4) July/August 2007.</p>	<p>Integrative review summarizing the findings of planned home birth studies. Discusses the body of evidence addressing the safety of planned home births under circumstances that emulate the elements of "first level care".</p>	<p>Studies of planned home births that emulate elements of "first level" care demonstrate consistency in the generally favourable results of maternal and neonatal outcomes, both over time and among diverse population groups. These outcomes are also favourable when viewed in comparison to various reference groups (birth centre births, planned hospital births and vital statistics). Data is expected to influence policy in support of planned home births, building a home birth infrastructure in parallel to the efforts to build capacity for facility-based birth. A randomized clinical trial is needed to provide a definitive answer about the relative safety of home births.</p>

<p>Health Canada. <i>Family Centred Maternity and Newborn Care: National Guidelines</i>. 2000, Millennium Edition.</p>	<p>Articulates Health Canada's guidelines for maternal and newborn services.</p>	<p>The <i>Guidelines</i> are organized from general principles to specific details. Chapter 1 begins with an introduction to the concepts of family-centred maternity and newborn care and a description of the basis of this care – the guiding principles. Chapter 2 describes the organization of services within a regionalized system of family-centred maternity and newborn care. The next four chapters provide guidelines for providing care during the childbearing cycle: preconception care, care during pregnancy, care during labour and birth and early postpartum care of the mother and infant and transition to the community. The next three chapters address specific topics of concern relative to family-centred maternity and newborn care: breastfeeding, loss and grief and transport. The final chapter describes the guidelines for the facilities and equipment necessary when providing care. Each chapter begins with guiding principles relevant to the aspect of maternity and newborn care under discussion and includes references to key literature.</p> <p><u>Limitations:</u> Does not address scope of practice, collaboration, interprofessional care issues; Provides guidelines, not recommendations for improvement.</p>
<p>Herschderfer, K. and Haneke, K. (2005) <i>Current Practice in Europe and Australia: A Descriptive Study</i>.</p>	<p>A background paper developed as part of the MCP2 project.</p>	<p>Describes the collaborative models of maternity care in France, Germany, The Netherlands, Sweden, United Kingdom and Australia. The report describes the national framework for practice in each country, including legal and regulatory issues, scope of practice, standards and guidelines, documentation and information transfer, financial and economical issues, medico-legal and liability issues, professional education and the number of professionals. The most common current model of maternity care is also described and models of collaboration within and between professions are discussed.</p> <p><u>Highlights:</u></p> <ul style="list-style-type: none"> ▪ The concept and criteria for collaboration differs considerably from country to country. ▪ Two issues may negatively affect collaboration: the difference in philosophy among maternity care providers and the difference in level of education of the various professionals with different backgrounds. ▪ Models of care are often 'tailor-made' to fit existing systems and changing circumstances. They reflect historical and cultural changes over time. ▪ Professions have historically and culturally become ingrained in the maternal newborn health systems, and these models may not be integrally or explicitly exported to other systems of care in Canada as such. Canada should look at the competencies of the professions studied and transpose them to existing professions in the Canadian health system.

<p>Lothian, J. & Romano, A. Promoting, Protecting, and Supporting Normal Birth: A Look at the Evidence. <i>Journal of Obstetrics, Gynecologic and Neonatal Nursing</i>, 37(1), (2008): 94-105.</p>	<p>Analysis of six evidence-based practices that promote, protect and support normal birth, and how nurses can provide care that reflects this evidence:</p> <ul style="list-style-type: none"> - promote physiological birth and avoid medically unnecessary induction of labour, - allow freedom of movement for the labouring woman, - provide continuous labour support, - avoid routine interventions and restrictions, - encourage spontaneous pushing in non-supine positions, and - keep mothers and babies together after birth without restrictions on breastfeeding. 	<p>Creating labour and birth environments that protect, promote, and support normal birth will require dramatic changes in the typical American hospital. Non-separation of mothers and babies may require a close look at nurses' habits and routines so that the radiant warmer is no longer seen as the only site for newborn care. It will require a shift in priorities such that establishing skin-to-skin contact, initiating breastfeeding, and protecting the mother-baby continuum are paramount, and routines and interventions are designed to accommodate the new relationship between the mother and the baby, not vice versa.</p> <p>The most problematic change is to shift away from routine continuous electronic fetal monitoring. The cost of reallocating and retraining hospital staff to safely implement intermittent auscultation protocols and the perceived need for continuous documentation of the fetal heart rate in the case of future malpractice claims are the most frequent excuses for the persistence of continuous fetal monitoring in the face of irrefutable evidence of harm.</p> <p>Interfering with the normal physiological process of labour and birth in the absence of medical necessity increases the risk of complications for mother and baby. Nurses are in a unique position to provide these care practices and to help childbearing women make informed choices based on evidence.</p>
<p>Midwives Association of British Columbia. Benefits of Midwifery to the Health Care System, A Case for Midwifery. Vancouver, British Columbia, February 2007.</p>		
<p>Organization for Economic Co-operation and Development (OECD) <i>Issue Paper on Supporting Midwifery</i>. Health Division Document 1998: 2.</p>	<p>Issue Paper/policy report describing the role of nurse-midwives in reproductive health care, especially in developing countries, as a basis for further development of Swedish health care co-operation in reproductive health. Explores the role of the midwife, midwifery education, professional responsibilities and relationships with other reproductive health professionalism, and outlines international support for midwifery.</p>	<p>National midwifery coverage has often been the single most important measure in reducing maternal mortality, the key concepts describing the role of the midwife being appropriateness (background) and coverage. The quality of midwifery education depends largely on the professional role of midwives in that country, while actual professional responsibility of midwives in a country influences the contents of local midwifery training curricula both in teaching and in practice (i.e., what a midwife may do as a professional is linked to the social status of midwives in a particular society). <u>Limitations:</u> Helps to fill existing knowledge on the history of midwifery in Europe (notably Scandinavia); focuses on challenges for midwifery in developing countries.</p>

<p>O'Halloran, P. et al. A Model for Developing, Implementing and Evaluating a Strategy to Improve Nurse and Midwifery Care. <i>Practice Development in Health Care</i>. Dec 2005 Vol 4 (4), p. 180-191.</p>	<p>Academic article describing the development of a model to underpin a strategy for nursing and midwifery in an acute hospital trust.</p>	<p>Strategy development for an integrated model includes values clarification, critical companionship and focus groups; the development of a process for implementation is based on a modification of the PARIHS (Promoting Action on Research Implementation in Health Services) conceptual framework.</p> <p>The methods for evaluating the strategy include a pre-test-post-test approach that measures the quality of nursing care, the degree to which the organization supports professional nursing care, the leadership styles of ward managers, and patient satisfaction with care. The model is offered as one that may be of use to others who wish to develop an integrated approach to strategic change (i.e., an approach in which the development, implementation and evaluation of strategic plans are informed by the core values of nurses and midwives).</p>
<p>Sutherns, R. Adding women's voices to the call for sustainable rural maternity care. <i>Canadian Journal of Rural Medicine</i>, 9(4), (2004): 239-244.</p>	<p>Exploratory research study (N = 36). Semi-structured narrative interviews in three rural study sites in south-central Ontario eliciting the perspectives of rural women on maternity care.</p>	<p>Evidence from the study demonstrates the need for integrated models of maternity care involving rural physicians, nurses and midwives. Rural women identify three features of maternity care that are particularly important: local, relational and informed choice.</p> <p><u>Limitations:</u> Review based on a small, non-random number of mothers in three rural sites.</p>

<p>The Society of Obstetricians and Gynaecologists of Canada. <i>A National Birthing Initiative for Canada</i>. January 2008.</p>	<p>Research report/framework proposes the need for a National Birthing Initiative for Canada to promote the national guidelines for the provision of family-centred maternity and newborn care.</p>	<p>There is a serious threat to the sustainability of the maternity care system and an urgent need for the implementation of multi-dimensional and multi-jurisdictional solutions in Canada to address the following trends: demographic and societal changes; increase in the number of babies requiring medical attention in intensive care units; human resource shortages among maternity care providers; and, regional disparities in the provision of maternity care services.</p> <p>Identifies the following priorities for action to establish a National Birthing Initiative:</p> <ul style="list-style-type: none"> - Listen to women’s voices: incorporating women’s input into their maternity care at all levels. - Facilitate maternity care stakeholder engagement, collaboration and networking: interprofessional, inter-governmental, inter-jurisdictional cooperation. - Establish a process for collection of data and information on maternity care providers and outcomes: particularly, there is inadequate data collected for midwives. Absence of a comprehensive human resource planning framework for midwifery has meant that information requirements at the national, provincial or regional level have neither been articulated nor defined. - Create standardized clinical practice guidelines for all maternity care providers: without standardized practice guidelines, it is not possible to share information, compare the effectiveness of practices and evaluate health outcomes. - Adopt standardized curriculum for post-secondary undergraduate and post-graduate education. - Establish interprofessional continuing education to manage risks, improve patient safety and facilitate collaborative women-centred practice: The key to increasing patient safety is to break down the traditional hierarchy and practices and direct focus onto teamwork, creating an environment that will facilitate multidisciplinary collaborative care (for example, SOGC’s “Salus” program). - Establish multidisciplinary collaborative maternal and newborn care models: these models are one mechanism that has the potential of addressing the health human resource crisis in the short term. <p>The <u>Multidisciplinary Collaborative Primary Maternity Care Project (MCP2)</u> has been instrumental in advancing this agenda.</p>
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<p>Society of Obstetricians and Gynaecologists of Canada. Policy Statement on Normal Childbirth. Unpublished draft. September 2008.</p>	<p>Policy statement from the Society of Obstetricians and Gynaecologists, endorsed by the Association of Women's Health, Obstetric and Neonatal Nurses of Canada (AWHONN Canada), the Canadian Association of Midwives (CAM), the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC) [endorsement pending].</p> <p>The policy statement and recommendations support best practice and serve to promote, protect and support normal birth.</p> <p>Normal labour: Spontaneous onset and progress of labour to a spontaneous (normal) delivery at 37–41+7 weeks' gestation, with a normal third stage. It can include pharmacological (opioids/inhalation) and nonpharmacological analgesia and routine oxytocic for the third stage.</p> <p>Normal (spontaneous) delivery/childbirth: Not assisted by forceps, vacuum, or Caesarean section, and not a malpresentation. It refers only to the type of delivery of the infant. It could therefore include induction, augmentation, electronic fetal monitoring, regional anaesthesia, and complications of pregnancy (hypertension, antepartum hemorrhage, etc). That is, the labour may be abnormal but the delivery is normal (spontaneous).</p> <p>Natural: The Compact Oxford English Dictionary defines this as "Existing in or derived from nature; not made, caused by, or processed by humankind." Childbirth is considered to be natural childbirth if there is not human intervention of any kind.</p>	<p>In the past quarter century, maternity care has undergone significant changes. Today, the use of technology in birth has become the norm, evident in the rise in medical interventions in low-risk births.</p> <p><u>Recommendations</u></p> <ul style="list-style-type: none"> ▪ Develop national practice guidelines on normal childbirth that address philosophy and practice expectations to provide a framework for all professional associations providing maternity health care and that include the following components: <ul style="list-style-type: none"> - Spontaneous onset of labour - Freedom of movement throughout labour - Continuous labour support - No routine interventions - Spontaneous pushing in the woman's preferred position - Use of fetal surveillance by intermittent auscultation - Institutions offering options for pharmacologic and non-pharmacologic approaches to pain relief (such as tubs/showers, access to natural light, environmental designs/adaptations, quiet area). ▪ Develop interdisciplinary committees to implement standardized unit policies on normal childbirth and all aspects of maternity care with membership from all contributing disciplines. ▪ Enhance the promotion among childbirth educators and maternity care providers of knowledge about and experience with the birth process and evidence-based practices so that women and families can be informed about normal birth; antenatal preparation requires a positive focus on practical skills for coping with labour and birth pain. ▪ Provide information and opportunities for discussion about natural childbirth to all pregnant women at low risk. This should include the information that unnecessary interventions increase risks to mother and baby. ▪ Enhance the promotion of expert knowledge and skills in normal childbirth among health care practitioners/professionals providing intrapartum care. ▪ Establish collaborative education opportunities on normal childbirth for maternity care providers. The aim of education and training programs is to build the confidence to support women who wish to give birth without technological interventions.
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<p>Tucker, J.S. et al. Should Obstetricians see Women with Normal Pregnancies? A Multicentre, Randomized Control Trial of Routine Antenatal Care by General Practitioners and Midwives Compared with Shared Care Led by Obstetricians. <i>British Medical Journal</i>. 312: 554-559. 1996.</p>	<p>A randomized control trial comparing routine antenatal care provided by general practitioners and midwives with obstetrician led shared care.</p> <p>Design: Multicentre randomised controlled trial.</p> <p>Setting: 51 general practices linked to nine Scottish maternity hospitals.</p> <p>Subjects: 1765 women at low risk of antenatal complications.</p> <p>Intervention: Routine antenatal care by general practitioners and midwives according to a care plan and protocols for managing complications.</p> <p>Main outcome measures: Comparisons of health service use, indicators of quality of care, and women's satisfaction.</p>	<ul style="list-style-type: none"> • Care by GPs and midwives improved continuity of care: there were fewer carers, non-attendances, and hospital admissions, and marginally fewer routine visits than with specialist led shared care; incidences of hypertension, proteinuria, pre-eclampsia, and induction of labour were also lower. • Overall there were few deviations from the care protocol, but a greater proportion of Rhesus negative women in the general practitioner and midwife group did not have an appropriate check for antibodies. • The women in both trial groups were equally “highly satisfied” with all aspects of their care; only a small minority of women in the general practitioner and midwife group said they would have liked to have seen a hospital doctor but did not. • Although there was no net benefit from routine specialist antenatal visits, over half of women developed some complication during their pregnancy; in the GP and midwife model of care, low risk women see a specialist when required and not at predefined routine visits.
<p>Verdict Explanation for the Inquest Into Death of Eoin Stalker.</p>	<p>Verdict explanation containing a brief synopsis of the evidence presented at the inquest into the death of Eoin Stalker, together with some explanatory remarks about the individual recommendations made by the jury.</p>	<p>Key Recommendations:</p> <ul style="list-style-type: none"> • All Ontario hospitals should provide clear direction to members of the obstetrical care team regarding all relevant policies concerning transfer of care, consultation and transport issues. The College of Midwives of Ontario’s (CMO) document, <i>Indications for Mandatory Discussion, Consultation and Transfer of Care</i>, and the Society of Obstetricians and Gynaecologists of Canada (SOGC) <i>Guidelines for Maternal/Fetal Transport</i> should be the basis for hospital protocols. • The Association of Ontario Midwives (AOM), the CMO, the Ontario Medical Association (OMA), the SOGC, the College of Physicians and Surgeons of Ontario (CPSO) and the Ministry of Health and Long-Term Care (MOHLTC) should establish a high standard of interprofessional communication and collaboration in providing optimum patient care and mutually respectful interprofessional relationships. • The Ontario Hospital Association should distribute <i>The Integration of Midwifery Services in Hospitals</i> and should require hospitals to identify and remove systematic or other barriers to allow midwives’ full integration into hospitals. The MOHLTC should review the <i>Public Hospitals Act</i> to ensure midwives can fully integrate into hospitals.

<p>Waters, D. et al. Midwifery-led care: Finding Evidence for an Antenatal Model. <i>Australian Journal of Midwifery</i>. Vol 17 (2): 16-20. 2004.</p>	<p>Conducted as the first phase of the Improving Patient Outcomes Project.</p> <p>Literature review focused on determining an evidence-base for the development of a midwifery-led antenatal model of care. In particular, evidence was sought for those elements of antenatal care that were proven effective and were valued by women.</p> <p>The paper reports on a systematic approach to reviewing literature in which the intuitive and practical experience of expert reviewers and clinicians contributes to assessing the overall quality of currently available research evidence. This combined approach ensures a judicious and sensitive application of available evidence to the development of safe and appropriate models of care.</p>	<p>There is good quality evidence that women are satisfied with receiving antenatal care from midwives and that antenatal visit schedules can be made more flexible. The literature provided practical assistance in defining maternity outcome measures but was not able to provide a strong evidence-base for all aspects of antenatal care.</p>
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Health Outcomes, Patient Safety/Risk of Harm

Authors, Title and Publication	Context/ Type of Document or Study	Main Findings/Recommendations
<p>Albers LL. (2001) “Evidence” and midwifery practice. <i>Journal of Midwifery and Women’s Health</i> 46: 130- 136.</p>	<p>Evaluation of evidence-based care as applied to midwifery research. It represents a paradigm shift for clinicians toward greater inclusion of research findings in patient care decisions.</p>	<p>Randomized trials provide the strongest evidence for a treatment or intervention; however, they have limitations that do not answer all clinical questions. Research using observational, descriptive, and qualitative methods also has a place in generating evidence for practice. Balancing the needs of individual women against what is learned from research with groups or populations is a challenge for midwives.</p>
<p>Bodner-Adler, et al. Influence of the birth attendant on maternal and neonatal outcomes during normal vaginal delivery: a comparison between midwife and physician management. <i>Wiener klinische Wochenschrift</i>, 116(11-12), (2004): 379-</p>	<p>Comparative study of low-risk maternity patients attended by certified midwives with that of low-risk maternity patients attended by obstetricians. (N = 2704). Department of Obstetrics and Gynaecology of the University Hospital Vienna during the period from January 1997 to July 2002.</p>	<p>Certified midwives are able to successfully provide prenatal care and delivery to low-risk maternity patients, with neonatal outcomes comparable to those of physician patients. The use of certified midwives supervised by obstetricians may provide the optimum model for perinatal care, particularly for those women who are low-risk maternity patients, leaving physicians free to attend to the high-risk elements of care.</p>

Authors, Title and Publication	Context/ Type of Document or Study	Main Findings/Recommendations
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Carr, KC. Developing an Evidence-Based Practice Protocol: Implications for Midwifery Practice. <i>Journal of Midwifery and Women's Health</i> . Vol 45 (6), November/December 2000	Description of "evidence-based practice", its importance to midwifery and guidelines for the development of an evidence-based practice protocol. The overall goal of this "guideline movement" has been to determine, according to current scientific evidence (rather than opinion), which therapies work the best.	Guidelines for the development of an evidence-based protocol include: identifying the clinical question, obtaining the evidence, evaluating the validity and importance of the evidence, synthesizing the evidence and applying it to the development of a protocol or clinical algorithm, and developing an evaluation plan or measurement strategy to see if the new protocol is effective. The major deterrent in practicing evidence-based health care is finding relevant evidence in a timely manner. As clinicians conduct more applicable research and electronic databases become more and more available, more user friendly, and more relevant to midwifery practice, this problem should be overcome.
Etches, D., Janssen, P., Klein, M., Reime, B. & Ryan, E. Outcomes of Planned Hospital Birth Attended by Midwives Compared with Physicians in British Columbia. <i>Birth</i> , (2007): 140-147.	Descriptive study comparing perinatal outcomes for planned home births attended by regulated midwives with those for planned hospital births. (N = 862). Comparison subjects who had similar obstetric risk status were selected from hospitals in which the midwives who were conducting the home births had hospital privileges. The study population included all home births that occurred between Jan. 1, 1998 and Dec. 31, 1999.	Women who gave birth at home attended by a midwife had fewer procedures during labour than those who gave birth in a hospital attended by a physician. They were less likely to have epidural analgesia, be induced, have their labour augmented with oxytocin or prostaglandins, or have an episiotomy. Comparison of home births with hospital births attended by a midwife showed very similar and equally significant outcomes. There was no increased maternal or neonatal risk associated with planned home birth under the care of a regulated midwife. The rates of some adverse outcomes were too low to draw statistical comparisons and ongoing evaluation of home birth is warranted.
Harvey, et al. Evaluation of satisfaction with midwifery care. <i>Midwifery</i> , 18 (2002): 260-267.	A randomized control trial (N = 194) undertaken at a tertiary referral centre in Alberta (Canada). The study focused on women with low risk pregnancy. The purpose of the study was to determine if there were differences in women's satisfaction with maternity care given by doctors and midwives. <u>Main outcome measures:</u> Labour and Delivery Satisfaction Index (LADSI); Attitudes about Labour and Delivery Experience (ALDE) questionnaire; Simple, Six-Question Satisfaction Questionnaire (SSQ).	Women in the midwife group reported significantly greater satisfaction and a more positive attitude toward their childbirth experience than women in the physician group. The SSQ demonstrated scores similar to the LADSI. Satisfaction in both groups was lowest at 36 weeks gestation and highest immediately postpartum. The SSQ measures similar dimensions to the LADSI but the agreement is not strong enough to recommend its use as a substitute at this time.
Janssen, P. et al. An Evaluation of Process and Protocols for Planned Home Birth Attended by Regulated Midwives in	Analysis of the process and protocols for planned home births by regulated midwives in British Columbia. Adherence to protocols was measured	Midwifery emerged as a self-regulated profession in British Columbia in 1998. Although studies show that planned home birth appears to be as safe as hospital birth, the northern climate and geography in Canada present unique challenges for communication and

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<p>British Columbia. <i>Journal of Midwifery and Women's Health</i>. Vol 48 (2), March/April 2003.</p>	<p>using documentation designed for the Home Birth Demonstration Project. Hospital and transport records for selected clients were reviewed by an expert committee and outcomes among Home Birth Demonstration Project clients were compared to outcomes among women eligible for home birth but planning to deliver in hospital.</p>	<p>transportation. <u>Highlights:</u></p> <ul style="list-style-type: none"> - Adherence to clinical and communication protocols was 96% or higher. - Planned home birth was not associated with an increase in risk but prevalence of adverse outcomes was too low to be studied with precision. - Midwives have demonstrated a high degree of compliance with reporting requirements and protocols. - Recommendations of an expert review committee have been implemented or are under review. <p><u>Limitations:</u></p> <ul style="list-style-type: none"> - Comparisons for birth outcomes of planned home versus hospital births were limited in scope and require ongoing study.
<p>Janssen, P. et al. Satisfaction With Planned Place of Birth Among Midwifery Clients in British Columbia. <i>Journal of Midwifery and Women's Health</i>. Vol 51 (2) March/April 2006.</p>	<p>Prospective matched cohort study comparing satisfaction with the birth experience among women planning home versus hospital birth. The Labour Agency Scale – a standardized 29 item scale for measurement of expectancies and experiences of personal control during childbirth – was used to measure satisfaction with place of birth. (Women planning home birth: N = 550; Women planning hospital birth: N = 108).</p> <p>In British Columbia, all midwives offer women meeting eligibility requirements for homebirth the choice to give birth in hospital or at home. Satisfaction can be attributed to planned place of birth, as the caregivers were the same in both settings.</p>	<p><u>Highlights:</u></p> <ul style="list-style-type: none"> - The mean overall score on the Labour Agency Scale among women who had planned a homebirth was significantly higher than those who planned birth in hospital. - Overall satisfaction with the birth experience was higher among women planning birth at home, although this difference was not statistically significant. - Among women whose actual place of birth was congruent with where they had planned, overall satisfaction was higher in the homebirth group. Although satisfaction with the birth experience was high in both the home and hospital settings, women planning birth at home were somewhat more satisfied with their experience, particularly if they were able to complete the birth at home. <p><u>Limitations:</u></p> <ul style="list-style-type: none"> - Non-random allocation of subjects to planned home versus hospital births; - Although differences were statistically significant, it is debatable whether they were clinically significant.
<p>Johnson, Kenneth C and Davis, B. <i>Outcomes of planned home births with certified professional midwives: large prospective study in North America</i>. British Medical Journal. 18 June, 2005. 330; 1416-1419.</p>	<p>Prospective cohort study of all home births involving certified professional midwives across the U.S. and Canada. (N = 5418).</p> <p><u>Main outcome measures:</u></p> <ul style="list-style-type: none"> - Intrapartum and neonatal mortality; - Perinatal transfer to hospital care; - Medical intervention during labour; - Breast feeding; - Maternal satisfaction. <p>The purpose of the study was to evaluate the safety of home births in North America</p>	<p><u>Highlights:</u></p> <ul style="list-style-type: none"> - Planned home birth for low-risk women in North America using certified professional midwives was associated with lower rates of medical intervention but similar intrapartum and neonatal mortality to that of low risk hospital births in the United States. <p><u>Limitations:</u></p> <ul style="list-style-type: none"> - Inability to develop a workable design from which to collect a national prospective low risk group of hospital births to compare morbidity and mortality directly.

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	involving direct entry midwives in jurisdictions where the practice is not well integrated into the healthcare system.	
Ontario Ministry of Health and Long-Term Care Midwifery Outcomes Report Database.		
Symon, A. et al. Self-Rated “No-“ and “Low-” Risk Pregnancy: A Comparison of Outcomes for Women in Obstetric-Led and Midwife-Led Units in England. <i>Birth</i> . Vol 34 (4) December 2007.	<p>Comparative study in outcomes for women intending to give birth in obstetric-led and midwife-led units and whose self-rated pregnancy risk level was “none” or “low.” Self completion questionnaires were distributed to mothers 8 days after the birth in 9 units (6 midwife-led; 3 obstetric-led) over a 6-month period.</p> <p>Debate in the United Kingdom about place of birth often concerns obstetric-led units and midwife-led units and relates to notions of risk and safety. Outcomes for these two types of unit are often not comparable because of the restricted selection criteria for midwife-led units.</p>	<p><u>Highlights:</u></p> <ul style="list-style-type: none"> - Mothers in midwife-led units spent shorter times in labour in the unit, received less analgesia, had fewer interventions and were more likely to have a normal delivery than women in obstetric-led units. - Since these mothers’ self-rated risk level was none or low, some comparability of outcomes is permissible. - Models of care appear to be significantly different in obstetric-led units compared with midwife-led units, leading to greater likelihood of intrapartum intervention, need for analgesia, and assisted or operative delivery. <p><u>Limitations:</u></p> <ul style="list-style-type: none"> - A randomized controlled trial examining such units would permit a conclusive examination of these outcomes. - Lack of sophistication of risk-rating tool. - Lower response rate (53%) due to postal questionnaire. - Lower response rate from obstetric-led units may have led to some bias.