Integration of midwifery care in Canada

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Birth is a natural process that sometimes becomes complicated. The shortage and unequal geographical availability of maternity health care providers in Canada is a long-standing problem.[1] In related research, Stoll and colleagues consider outcomes over 10 years for people giving birth in British Columbia, comparing those whose primary provider was a midwife with those who received care from a physician.[2] They found that midwives provide safe care across all levels of medical and obstetric risk as an integrated part of the BC health care system. An increasing role of midwifery services is part of the solution to Canada's problems regarding access to obstetric care; however, careful service planning is required to ensure that all patients can access a different level of care should they need it.

The Society of Obstetricians and Gynaecologists of Canada and the Canadian Medical Association are long-standing supporters of integrating midwifery into the provision of birthing care, despite historical misgivings.[3,4] Importantly, this includes returning birth to Indigenous communities.[5] Midwives can provide continuity of maternal care and spend an amount of dedicated time with their patients that cannot be matched by physicians. However, Stoll and colleagues' findings are not yet generalizable to all jurisdictions in Canada, where work to regulate, integrate and fund midwifery care is less advanced than in BC. Midwifery has been regulated in BC since 1998 and is well integrated within that health system. In the Yukon, regulation of midwifery took effect only in 2021, and staffing shortages currently limit the integration of midwives in intrapartum care in the territory.[6] Midwifery became regulated in Prince Edward Island only in 2022.[7]

The context of the related research is important when considering its findings. Stoll and colleagues defined the most responsible provider (MRP) for a birthing client as the one who provided care for the greatest proportion of the client's stay in the health care facility. If another service participated in care or assumed responsibility for the delivery for a short period, the MRP did not change. This is the patient-centred, integrated care model that the linked research showed to be working well in BC. Obstetric clients who are at low risk can and should be cared for by a broad spectrum of trained providers, but providers capable of specialist interventions should be readily accessible in case of complications. A system of integrated service delivery is the safest model of birthing care.

Many patients do not wish for their birthing provider to be a doctor, nor for there to be medical interventions in their birth — the secondary outcomes in the related study. Patient autonomy is a central ethical principle in health care. A person's choice of birthing provider is often influenced by distrust in the established medical system, based on real personal, cultural or historical harm. Many people who live in rural and remote areas want to receive care close to their home; greater availability of midwives can allow people to give birth in the location of their choice, perhaps offering them a more culturally safe birth experience or a better sense of control over the process.[8] However, for the BC system to be replicated elsewhere, many more registered midwives are needed across Canada; this could be addressed through domestic training programs and by licensing foreign-trained providers.

Although the related study found that patients with a midwife as the MRP had fewer medical interventions, avoiding medical intervention is not necessarily a priority for all people who give birth. Some people value the freedom to choose to make use of anesthesiology services (including epidural) during labour, and such services depend on provider availability. Spontaneous vaginal birth is also not always the most desired outcome for all patients. Although planned cesarean delivery by maternal request remains controversial, a 2021 Ontario study found that it was associated with a decreased risk of short-term adverse outcomes compared with planned vaginal delivery, which provides further evidence to support patient choice.[9]

Stoll and colleagues found that patients were more likely to have a vaginal birth after a cesarean delivery under the care of a midwife. Trial of labour after previous cesarean delivery is a reasonable or even recommended choice in the absence of other risk factors.[10] The overall risks include a 25% chance of having an emergency cesarean, and a 0.5% chance of a uterine rupture with increased perinatal morbidity and mortality.[10] These risks, although small, are unacceptable to some patients. Patient choice will also be influenced by previous birthing experiences. Consent requires unbiased communication of perinatal risks and benefits, with the decision reassessed as needed throughout the birthing process.

For many people who give birth, midwifery is a safe, evidence-based, appropriate option that they should be able to choose to access. For others, obstetric care from a physician may be preferred or more appropriate. Therefore, trust and willingness to collaborate must continue to develop between physicians and their midwife colleagues; this will be enhanced by careful planning of services that can ensure safe systems of integrated obstetric care in all Canadian jurisdictions.

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