

BORN IN ALBERTA

Midwives struggle to bring a healthy new attitude into the birthing world

BY GUNHILD HOOGENSEN

More and more Albertans are learning what many people in other industrialized states already know: midwifery services are essential to a modern health care system. While the integration of midwifery is known to reduce overall health care costs and improve maternal and infant care, and although midwifery is a recognized profession in Alberta, fewer than 1 per cent of pregnant women give birth under the care of a midwife. Midwifery care, in this province, remains largely unknown and inaccessible.

Critical to general and equal access to midwifery services in Alberta is the issue of hospital admitting privileges for non-physician practitioners. Admitting privileges are granted independently by each of Alberta's 17 Regional Health Authorities (RHAs), and, so far, only



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two have granted these to midwives.

An even greater barrier is cost. Midwifery services are not covered by Alberta Health Care. Since 1994, when the Alberta government passed legislation to regulate midwifery, midwives have been undergoing registration and licensing in the province. Registration requires midwives to obtain malpractice insurance, the cost of which is not alleviated by a professional association, and therefore drastically increases the cost to the client. That, in itself, puts midwifery care out of the range of most Albertans.

But the greatest obstacle is a deeply rooted ambivalence, even hostility, toward midwifery, along with a general ignorance about normal birth.

To argue that interventions—C-sections, forceps, vacuum extraction, episiotomies, inductions, drugs—are always necessary, is to argue that women’s bodies are not designed to give birth without some sort of assistance.

Alberta attitude: childbirth potentially pathological

Birth in Alberta is a medical event. According to Alberta Health (1999), more than 99 per cent of births take place in hospital each year. Of those, only 10 per cent are “normal,” non-interventionist deliveries. Ninety per cent of Alberta women receive one or more interventions, including C-sections, forceps, vacuum extraction, other instrumental deliveries, episiotomies, inductions and drugs. To argue that these interventions are always necessary is to argue that women’s bodies are not designed to give birth without some sort of assistance; “normal” birth is rare. But history and practice in other parts of the world do not support this attitude. Women in the past and now give birth successfully without being subjected to various interventions; more often than not, midwives have been in attendance.

Interventions and place of birth are central issues in the debate between the midwifery and medical models of practice. In the medical model, interventions in childbirth are a reflection of a deeply held belief that childbirth is potentially pathological. Anything can go wrong, and it is necessary to give birth where there is ready access to technology to prevent maternal or neonatal death. If childbirth is potentially pathological, then one must give birth in hospital and accept any and all interventions as determined by a doctor.

The midwifery model assumes that childbirth is natural and normal, and the best results are obtained when the birthing mother is free from interference. Interventions generally serve to complicate rather than simplify childbirth. When birth is left to proceed on its

own, emergencies are rare and can be dealt with expeditiously if they arise. If birth is safe and reliable, then out-of-hospital venues for birth should be considered, with non-interventionist care.

The dispute between the two models is certainly heated. A community socialized to fear childbirth does not easily

renounce its faith in the medical system. A great deal of confidence, if not reverence, has been bestowed upon the medical model. Improvements in education and technology have enabled physicians to attend successfully to some complications that would otherwise result in death. In Alberta at present, birth is firmly rooted in the medical model.

Increasing intervention: the fetal heart monitor

According to many in the medical community, a labouring woman requires constant monitoring to detect possible fluctuations in the fetal heart rate that might indicate fetal distress. This monitoring is only available in hospital. Midwives at home listen to the baby’s heart intermittently with a fetoscope or Doppler. Some obstetricians argue that such periodic monitoring misses subtle changes of fetal heart rate, thereby increasing the

chances of undetected fetal distress. But in general, medical research does not support this claim. Even obstetrical textbooks acknowledge the results of studies demonstrating the inefficacy of electronic fetal heart monitoring. In *Obstetrics: Normal and Problem Pregnancies*, Gabbe and his colleagues write:

“In most prospective randomized studies, the incidence of neurologic damage and perinatal death associated with



This 1924 Department of Public Health poster typifies early attitudes toward midwives.



Midwifery was subjected to a flurry of media scrutiny following the death of an infant in May 1998.

the use of electronic fetal heart rate monitoring is not significantly lower than that documented with older methods ... In several trials, electronic fetal heart rate monitoring was associated with an increased incidence of Caesarean delivery. Consequently, the routine use of electronic fetal monitoring for intrapartum (during birth) fetal evaluation has been disparaged by some.” Obstetricians continue to use the fetal heart monitor with regularity as they can be “virtually” guaranteed (98 per cent) a positive outcome. If the baby *is* in actual distress, action is taken to remove it from the mother. Even if the baby has no distress, action still results in a positive outcome. Additionally, there is the “unacceptably great expense involved in providing the one-on-one nursing that is mandatory to perform adequate intermittent fetal heart rate auscultation.” Saving time and money makes the fetal heart monitor attractive.

In spite of fetal heart monitoring, intrapartum and neonatal deaths through asphyxiation/cerebral birth trauma increased in Alberta by 3 per cent from 1995 to 1996, according to Alberta Health (1999). A number of the 1996 deaths (14 of 32) were considered “possibly preventable,” and one factor associated with these deaths was “the failure to recognize or a delay in responding to fetal heart rate abnormalities.” Two of the 32 neonatal deaths occurred during home birth. Even if both were considered “possibly preventable” (this was not indicated), that still leaves 12 “possibly preventable” deaths in hospital. Rarely do medical personnel, public educators or the media address this truth: babies will die in hospital, even with the “best” technology close at hand.

The media

The World Health Organization’s 1986 *Report on Health Promotion and Birth* stated the following on the subject of media wisdom surrounding birth: “Radio and television producers, and even science and medical writers, are, on questions of childbearing, frequently unaware of the often biased nature of information presented by some health professionals, or of the scientific validity of much information presented by community and public interest groups.”

Midwifery has been the subject of the occasional informative article, and we are frequently kept up to date regarding the latest policy initiatives, such as the recent award of hospital privileges to seven Calgary midwives, or that the first hospital-midwife delivery took place just outside the hospital doors. These reports are nonetheless low profile.

When midwifery receives high profile attention is in the rare event of a death, generally not mirrored or balanced by reportage of a similar event occurring in hospital under the care of a physician. The coverage in the *Calgary Herald* in May 1998 of a home birth neonatal death is a case in point. Heated and emotional, the debate about the safety of midwife-attended home birth versus that of physician-attended hospital birth came to the fore with the news that a home birth in August 1997 resulted in the death of a baby. The parents contacted police in March of 1998 when told by a local obstetrician that their baby likely would have lived had he been born in hospital. In the May 13, 1998 issue of the *Herald*, the expert medical opinion prevailed: “...if the mother had been in

A study of 24,092 pregnant women found no significant differences in perinatal mortality between home and hospital. But low Apgar scores, severe lacerations, and medical interventions occurred more frequently in the hospital group.

hospital the fetal distress would have been picked up much earlier, a Caesarean section would have been performed and a healthy baby delivered. “They would have taken home a live, healthy, normal baby instead of going to a funeral.”

The baby died of asphyxiation, or oxygen deprivation. According to the obstetrician quoted in the May 25, 1999 *Herald*, this could have been prevented with better monitoring of the mother and fetus using the electronic fetal heart monitor. “A midwife can check for a heart beat with a fetoscope or a doptone (a more powerful form of stethoscope) but neither instrument can show subtle patterns that indicate fetal distress as the placenta gradually stops supplying oxygen.” With a fetal heart monitor, medical personnel can “detect such oxygen deprivation early, and ... upon detection the baby would be quickly delivered via Caesarean section.”

Letters, commentaries and editorials followed, many supporting midwifery care but others expressing the commonly held view that birth is safer in hospital. The debate in the *Herald* eventually died down, focusing instead on Alberta obstetricians’ demands for more money. A year later, no longer front-page news, the midwife who attended the stillbirth of August 1997 was exonerated of any criminal wrongdoing.

Media coverage of a home-birth death often evokes outspoken medical arguments in favour of hospital birth. Publication of statistics suggesting the alleged high risk of home birth would be enough to convince most readers that hospital is the safest place to give birth.

“Home-birth deaths 2.5 times hospital rate” blared a headline in the *Herald* of May 14, 1998, the article citing recently released statistics from the Alberta Medical

Association (AMA). However, the statistics were incorrectly cited in the *Herald*, indicating five neonatal deaths in 406 home births, as opposed to the actual four in 406 (Alberta Health, 1999). Nonetheless, the numbers seemed alarming.

Yet the AMA “cautioned that the number of home births on which the percentage is based is low.” The authors of the 1999 Alberta Reproductive Health: Pregnancy Outcomes Report at Alberta Health and the AMA warn against misuse of the numbers as well: “Rates may be based on small numbers and are therefore not statistically reliable. Caution should always be exercised in interpreting these rates.” So few births occur at home in Alberta that the statistics derived from these small numbers indicate very little.

Whereas from 1993 to 1995 the home birth neonatal death rate was 0.98 per cent, the period from 1989 to 1991 saw no deaths whatsoever, a 100 per cent success rate—not reported in the media. In addition, rates recorded by Alberta Health and the AMA are not results

of purposeful or comprehensive studies, and are retrieved from a variety of sources, making a proper comparison of results difficult.

The science

A detailed study has been conducted at the Foothills Hospital in Calgary through its nurse-midwifery program, which operated from 1991 to 1998 and ended when it became apparent that funding for midwives was not on the horizon. The study, operating as a randomized controlled trial, took place between February 1992 and August 1994, when participants were randomly assigned to nurse-midwifery or physician care. The midwifery



Home examinations are more comfortable and less stressful than visits to clinics or hospitals.

regional implementation committee reported in 1996 that “this study indicated lower rates of interventions and diagnostic testing in the nurse-midwifery group as compared to the physician group. Although these indicators were lower, clinical outcomes were shown to be as good or better than those in the physician group.” The rate of C-section was 4 per cent for midwives, compared with 15.1 per cent for physicians. Midwives’ instrument deliveries were 15.5 per cent as compared with the physicians’ 32.9 per cent. Epidural anaesthesia was 12.9 per cent for midwives as compared with 23.7 per cent for the physicians. Where midwives ordered ultrasounds for 37.6 per cent of their clients, the physicians ordered the same for 80.6 per cent.

The argument that higher rates of intervention are justified by a better rate of neonatal outcome was not borne out by the evidence. Apgar scores indicating the well-being of the newborn are based on tests conducted at specified intervals immediately after birth; 7-10 is normal. Apgar scores below 7 at one minute past birth were 13.9 per cent for the midwifery group, but 29 per cent for the physicians’ group. The Apgar scores did not differ significantly between groups after five minutes. These results provide substantial support for midwifery services in hospital.

But they do little to speak to the viability and safety of birth in the true territory of the Alberta midwife—outside of hospital. Albertans can look to numerous clinical studies, carried out in the 1980s and 1990s, evaluating the safety of home birth, one conducted in Toronto and many others conducted in the Netherlands, the United States, Australia, New Zealand and Great Britain. Published in medical journals such as *Birth*, *The British Medical Journal*, *The American Journal of Public Health* and *Obstetrics and Gynecology*, study after study confirms that home birth is an acceptable and safe alternative to hospital birth for most candidates, and that these births sustain far fewer interventions than their hospital-delivery counterparts. A study published in *Birth* measured mortality and morbidity in 24,092 pregnant women. Perinatal mortality did not significantly differ between home and hospital, but significant differences were noted in neonatal and maternal outcomes: low APGAR scores, severe lacerations and medical interven-

tions all occurred less frequently in the home birth group as compared with the hospital group.

The Alberta experience

The midwifery regional implementation committee at Alberta Health has recommended the integration of midwifery into the Alberta health care system. Seven years of research and consultation resulted in the committee’s October 1996 document, *Midwifery Services in Alberta*, which includes this observation: “Midwifery offers women and the health system a number of benefits. Women using midwifery services are generally very satisfied with the midwifery care they receive. This satisfaction is further supported by positive clinical outcomes. These outcomes have interested health system adminis-

trators, and combined with midwifery’s potential cost-effectiveness and fit with health system restructuring, this has led to a resurgence of interest in offering women the option of using midwifery services within the health system in Alberta.”

The report cites several benefits of midwifery. Care from a single knowledgeable and skilled practitioner is continuous throughout the maternity experience because midwives provide care from pregnancy through labour, birth and the postpartum period. The midwife knows and involves the family and is on call to provide support.

Women have indicated that they want more control over their childbearing experience, and midwifery focuses on empowering women and facilitating informed choice. Many women choose midwifery because they want to birth at home. They choose midwives to provide safe and supportive care for themselves, their babies and families. Studies by Kitzinger (1992) and Kerssens (1993) show that mothers are very satisfied with their home birth experience, primarily because of increased intimacy and control over their birthing environment. Finally, women are increasingly seeking “natural and non-interventionist” approaches to health care in general, and midwifery, with its belief in childbirth as a natural life process, fulfills this desire.

The report supports its findings with studies conducted in Alberta, Ontario and the Netherlands. Not only does it chronicle the positive clinical outcomes resulting from the midwife-client relationship, but it also cites the eco-



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conomic, personal, and health benefits that work together to result in a healthy mother and baby.

The Alberta government has not been unaware of the advantages of including midwives in the health care system. In the spring of 1999, Alberta Health announced the initiation of a midwifery demonstration project which would provide funding for 150 midwife-attended births, shared between five RHAs (Capital, Calgary, Westview, David Thompson and Headwaters), contingent on midwives receiving hospital-admitting privileges *in all five RHAs*.

On December 17, 1999, amendments to the Operation of Approved Hospitals Regulations came into force whereby non-physician health practitioners, such as midwives, were included among those eligible for hospital admitting privileges. But being eligible does not automatically mean obtaining privileges, however, since, under the 1996 health care restructuring amendments to the Hospitals Act, the grant of admitting privileges is at the discretion of each RHA. Westview granted privileges in May 2000 and also implemented its own pilot project of integrating midwifery and medical services in hospital, funded through the Alberta Health and Wellness Innovations Fund. David Thompson RHA planned to have admitting privileges in place by October 2000, and will wait to see if any midwives apply. The Capital RHA will probably have privileges in place in the near future, but likely limited to those midwives and clients participating in the demonstration project. There appears to be very little movement on implementing privileges in the Headwaters RHA. Calgary granted privileges in August 2000, but midwifery care will remain unfunded there until its fellow RHAs complete the process of granting admitting privileges. These RHAs, of course, are part of the demonstration project which is also the only source of funding at present; it is uncertain whether any of the other 12 RHAs will bother to explore midwife privileges at all.

As a result, midwifery in Alberta is still largely synonymous with home birth, as it is primarily in the home or the birth centre that a midwife can practise as the primary caregiver. Fewer than 1 per cent of Alberta families birth at home, so the majority of the birthing population does not access midwifery care. Little government or media effort has been directed toward public education and midwifery promotion, perpetuating the medical mythologies against safe childbirth alternatives. Due to the parochial activities at many RHAs, and to a lack of information and funding, Albertan families have little choice but to subject themselves to medical birth.

Gunhild Hoogensen has a PhD in political science, and teaches at Athabasca University. She presented a more detailed version of this paper examining the politics of birth at the 1999 Women's World Congress held in Tromsø, Norway, in June 1999. She has birthed three children with the assistance of midwives.

MIDWIFERY SOURCES AND RESOURCES

Since 1998 midwives have been registered and licensed to practise. Currently, registration is issued under the authority of the midwifery committee of Alberta Health and Wellness, Health Workforce Planning Branch.

Midwives must meet the requirements for registration annually. Their scope of practice includes providing primary care to pregnant women and their newborns. Midwives have access to laboratories and diagnostic services, and are able to consult and refer clients to specialists when needed.

■ REGISTERED MIDWIVES IN ALBERTA

EDMONTON

Passages Midwifery (780) 465-4252

Barbara Scriver, Noreen Walker

Birth Choices Midwifery (780) 413-6142

Joanna Greenhalgh, Maureen Ellis,
Kerstin Flanagan, Linda Moore, Bev O'Brien

JoySpring Midwifery (780) 464-2893

Cathy Harness

Gibbons & Tutt (780) 413-8982

Donna Gibbons, Marie Tutt

With Woman (780) 425-0916

Annita Damsma

RED DEER

The Birth Place (403) 342-4661

Sharyne Fraser

ROCKY MOUNTAIN HOUSE

Blessing Way Midwifery (403) 845-3084

Barb Bodiguel

CALGARY

Arbour Birth Centre (403) 286-5256

Briar Hill Midwives (403) 289-8334

Meryl Moulton, Penny Salkeld, Joy West-Eklund

Birth Partnership (403) 246-8986

Arlette Allyjan, Bobbie Fraser, Patty Lenstra,
Diane Rach, Sylvia Spayne

CANMORE

Jo Pedersen (403) 678-6009

LETHBRIDGE, MEDICINE HAT, ROLLING HILLS

Cherry Maclagan (403) 964-2010

FORT SMITH, NWT

Child Earth Resources (867) 872-5516

Lesley Paulette

■ SUPPORT GROUPS

EDMONTON

Association for Safe Alternatives in

Childbirth (780) 425-7993 (www.asac.ab.ca)

CALGARY

Birth Unlimited (403) 237-8839