## Rural Midwifery

To the old and now illegal unlicensed practitioners these new health professionals are "midwives in suits." Can this new breed help sustain maternity care services for rural women, or are they yet another destabilising force, brought in from outside?

### The Ontario Experience

Midwifery as a licensed profession has its longest history in Ontario. Midwives in Ontario are expected to practice in pairs. Where special circumstances exist (eg isolation) the College of Midwives (the CMO) may, or may not, give special dispensation for the midwife to function in conjunction with another person who is not certified in midwifery. A special application describing the circumstances and the qualifications and the role of the specified non-midwife must be submitted to the CMO. In a hospital setting this dispensation might be given to a specific nurse(s) but it could be given to a lay person.

Rural maternity care in Ontario is in serious decline. Rural doctors are being faced with relatively high stress but low practice volumes in maternity, occupational stressors of high volumes in everything else, and many have chosen not to attend births. Many hospitals have had to, as a direct result, close their maternity services. Unfortunately the medical literature shows that women who have to travel out of their community for maternity care fare significantly worse than when those services are available locally. The scope of practice of rural physicians in maternity care and emergency resuscitation and stabilisation is much broader than that of midwives in Ontario. The CMO has very good and explicit guidelines of the limits of this scope and indications for transfer of care.

There are few models of rural midwifery in Ontario as most practitioners have privileges at large city hospitals. Huntsville and Chatham tend to be on the rural most end of the spectrum, but both have obstetricians on staff. The only rural site where midwives have privileges at a hospital without an obstetrician as backup is just south of Owen Sound, in Markdale, Centre Grey General Hospital. This hospital is in a cluster of small

hospitals in the Grey Bruce region. It has 38 beds and has 73 births. There is no cesarean capacity on site but the hospital 20 minutes away does. There is a pair of midwives that have privileges at that hospital for five years now. Doctors and midwives are credentialed in the same manner and both require ten monitored deliveries prior to receiving full status. Most of the midwives' deliveries occur in the community although some do occur in the hospital. The medical staff have not had any problems with the arrangement and do consults for the midwives when the situation falls outside of the midwife scope of practice such as augmentation or induction. While the care in such circumstances is transferred to the doctor, because of trust and mutual respect, now the care often gets transferred back to the midwife for the delivery.

There are several issues surrounding such an application of midwives for privileges and its appropriateness. Most of the issues are those of perception that range between "midwives give better care" and, "we cannot work with midwives". Other than recognition that these perceptions exist I strongly urge everyone to ignore them as divisive and irrelevant.

The only focus that is important is how this affects the current service offered by the hospital for the community. This is uncertain. While most rural service volumes are low, and don't require someone who just does low risk maternity care, and a midwife doesn't have the same scope of practice as a physician, one can conceive that a midwife could be helpful as giving the community more choice and being another person that one can sign out to when one leaves town (albeit only for OB), sit on committees etc. This would depend on the personalities involved, but the example in Markdale is positive, and they have expressed willingness in helping others modify their hospital regulations to enable this to happen.

On the other hand, if the applicant(s) has no real commitment to the community, and particularly if they only wish to have the hospital resources as backup, the matter tends to be detrimental. One concern is the risk of conflict if simultaneous service commitments occur in another setting and the rural hospital. Which would the midwife attend and how would the other client be served? The risk of undermining service volumes in the hospital itself, experience of the nursing staff and by the physicians, to the point that the service will be closed, is probably not as significant as is the risk of sending the message to maternity nursing and physician staff that they are not important, wanted or needed. In such a case the needs of the community might be better served if lines of communication are developed to better allow care to be

transferred to a physician when situations arise that require a hospital birth, rather than privilege the midwife.