

An OB's perspective on:
Working with Midwives, and Home Birth



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Conflict of interest

- I was a 12 lb VBAC delivered (in hospital) by a midwife.....



Ontario births

- **Ontario** ~130 000 deliveries PA
 - 85% Obstetricians
 - 15% Family practice ↓ & Midwifery ↑
- **Toronto** 23 hospitals ~ 62,000 births
- **Mount Sinai 2008:**
 - 6,409 births (~ 60% “high-risk”)
 - OB: 5593
 - FP: 607
 - MW: 201
- raw CS rate: 33.8%







Midwifery at MSH



Midwifery in MSH since 2000

- ~ 200 hospital births / year
- ~ 80 planned home births / year
 - approx 20% transport in labour
- intrapartum consult rate:
 - initially ~ 50%
 - now ~ 20%



Working together...





Midwifery at MSH



Midwifery participation in MSH :

- grand rounds
- MORE^{OB}
- breech delivery etc
- conference planning and presentation: (Primary Maternity Care, OB Malpractice)
- interdisciplinary education



Committees: L & D planning Group, Breastfeeding, Q. A., Rounds Planning, Mother Baby, Family Practice Dept etc



What's in a name?

Dictionary.com

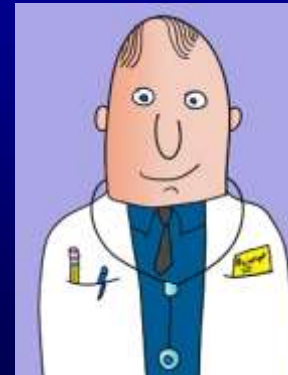
Client:

- a person who engages the professional advice or services of another <a lawyer's *clients*



Patient:

- an individual awaiting or under medical care and treatment b: the recipient of any of various personal services



Legal Actions in Ontario

- Midwifery is a young profession
- One legal case involving planned home birth (pre-legislation and about ECV not birth place)
- **Mount Sinai MORE^{OB}:**
 - MW critical event & near miss rates smaller than those for MDs



Midwife-led versus other models of care for childbearing women

Cochrane Database

2008

11 trials of 12,276 women

Midwife-led models of care were:

less likely:

- antenatal hospitalisation, regional analgesia, episiotomy, instrumental delivery and fetal loss before 24 weeks' gestation.

more likely:

- no intrapartum analgesia/anaesthesia, spontaneous vaginal birth, to feel in control during labour and childbirth, attendance at birth by a known caregiver and initiate breastfeeding and to have a shorter length of hospital stay.
- no statistically significant differences between groups for overall fetal loss/neonatal death or fetal loss/neonatal death

AUTHORS' CONCLUSIONS:

“All women should be offered midwife-led models of care and women should be encouraged to ask for this option.”



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Is home birth crazy?



Is home birth crazy?



Ontario Home Births

- Since legislation of midwifery in 1994, there have been approximately 25,000 planned home births attended by registered midwives.
- Currently there are about 2,500 per year, representing <2% of the births in the province and 24% of midwifery attended births.



Guidelines re Home Birth

Organisation	Recommendation
SOGC, 2003	informed choice
CPSO, 2001	informed choice
ACOG, 2008	hospital birth
AMA, 1998	hospital birth
RCOG and RC, 2007	home birth



RCOG and RCM

- “support home birth for women with uncomplicated pregnancies. There is no reason why home birth should not be offered to women at low risk of complications and it may confer considerable benefits for them and their families. There is ample evidence showing that labouring at home increases a woman’s likelihood of a birth that is both satisfying and safe, with implications for her health and that of her baby.”
- **Royal College of Obstetricians and Gynaecologists/Royal College of Midwives, Joint statement No.2, April 2007**



Home Vs Hospital cohorts

PUBLICATION		NUMBER	and COUNTRY	RESULT
Johnson:	BMJ, 2005	5,418	U.S and Canada	+
Mori: 2008	BJOG,	6, 314, 315	England & Wales	=
Blix:	Tidsskr, 2008	30, 204	Review 10 studies	=
Berghella	AJOG, 2008	“Evidence-based labor and delivery”		-
De Jonge:	BJOG, 2009	529,688	Dutch	=
Janssen:	CMAJ, 2009	1,314	British Columbia	=
Hutton:	Birth, 2009	13,384	Ontario	+

Berghella et al

Home birth has never been studied in an adequately powered randomized trial. The only trial published on this subject randomly assigned just 11 women, and was too small to draw any conclusions.⁸ Possibly because of this lack of data, there are diverging opinions on the safest, most effective setting for labor even in western countries, with about 30% of Dutch births occurring at home, vs < 1% of US births. Women with risk factors for abnormal outcome should deliver in a hospital setting. The safety and effectiveness of home birth needs further research, and for now can only be examined through randomized trials by evaluating the evidence for "home-like births" (recommendation: I; quality: poor; Table 2).



Cochrane Database Meta-Analysis

- A meta-analysis of observational studies has suggested that planned home birth may be safe and with less interventions than planned hospital birth.
- Olsen O, Jewell MD. Home versus hospital birth. *Cochrane Database of Systematic Reviews* 1998, Issue 3. Art. No.: CD000352. DOI: 10.1002/14651858.CD000352.



What can hospital staff do?

- when a midwife calls in with a home birth transport on the way, trust her assessment and respond
- call in on-call staff, as necessary
- build an environment of trust and open communication
- a respectful and efficient reception in hospital is a very important component of safety and the ethical thing to do.



Caveats

1. Patient selection.



SETTING: UK databases 2002-5.

PARTICIPANTS: 8676 women (7214 NHS; 1462 IMA).

MAIN OUTCOME MEASURES: everything important!

CONCLUSIONS:

“Healthcare policy tries to direct patient choice towards clinically appropriate and practicable options; nevertheless, pregnant women are free to make decisions about birth preferences, including place of delivery and staff in attendance.

While clinical outcomes across a range of variables were significantly better for women accessing an independent midwife, the significantly higher perinatal mortality rates for *high risk cases* in this group indicate need for a review of these cases”

BMJ. June 2009

Symon A et al

School of Nursing and Midwifery, University of Dundee

Caveats

1. Patient selection
2. Planned home birth but transferred to hospital



Intrapartum-related perinatal mortality rates for booked home births in England and Wales: 1994 to 2003.

OBJECTIVE: The objective of this study was to obtain the best estimate of intrapartum-related perinatal mortality (IPPM) rates for booked home births.

SUBJECTS: All births in England and Wales, including home births (intended or unintended) occurring between 1994 and 2003.

CONCLUSIONS: "The results of this study need to be interpreted with caution due to inconsistencies occurring in the recorded data. However, the data do highlight two important features. First, they suggest that IPPM rates for home births do not appear to have improved over the study period examined, even though rates did so overall. Second, although the women who booked for home births and had their babies at home seemed to have a generally low IPPM rate, those who required their care to be transferred to hospital did not.

Women who book for home births should be offered comprehensive evidence-based information about the potential benefits, risks and uncertainties associated with their choice of birthplace by the healthcare professional responsible for supporting their decision. It is of considerable concern that the data recorded nationally in England and Wales do not provide accurate information about when and why a transfer from home to hospital booking occurs and about their outcomes"

Mori R.

- National Collaborating Centre for Women's and Children's Health, London, UK.

Conclusions

1. working with midwifery in the team is a pleasure
2. womens' choices should always be respected
3. selection of patients is important
4. home birth is a safe option
5. audit and reporting is essential



Thank you

