MODEL OF MIDWIFERY PRACTICE

DEFINITION OF A MIDWIFE

> A midwife is a person who, having been regularly admitted to a midwifery educational programme duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

International Definition of the Midwife.

SCOPE OF PRACTICE OF THE MIDWIFE

The International Definition of a Midwife goes on to state:

> The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice to during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in the mother and child, the accessing of medical care or other appropriate assistance when necessary and the carrying out of emergency measures when necessary.
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> The midwife has an important task in health counselling and education, not only for the woman but also within the family and the community. The work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.
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> A midwife may practise in any setting including the home, community, hospitals, clinics, or health units.

This International definition, updated in 2005, is supported by the International Confederation of Midwives(ICM). The ICM definition of a midwife and has been consistently supported by the International Federation of Gynaecologists and Obstetricians(FIGO), and the World Health Organization (WHO) since 1972.

MODEL OF MIDWIFERY PRACTICE

The midwifery model of practice as developed in British Columbia is autonomous, community-based primary care, and incorporates the principles of continuity of care, informed consumer choice, choice of birth setting, collaborative care, accountability and evidence-based practice. Together with the *Philosophy of Midwifery Care* and the *Code of Ethics*, these fundamental principles define the midwifery model of practice.

COMMUNITY-BASED PRACTICE

Midwives are primary caregivers in autonomous practice within their communities. Midwives must acquire admitting and discharge privileges at hospital maternity units and, where available, birth centres, enabling them to provide care in all settings. Midwives will deliver their services within small group practices, enabling them to share call while providing 24-hour availability to their clients. Antenatal care may be provided in midwifery clinics, offices, or women's homes. Midwifery care for labour, birth and early postpartum will be provided in a setting chosen by the woman. Midwifery care during the early postpartum period, for most women and their newborns, is generally best provided in the home.

PRIMARY CARE

A primary caregiver is a practitioner who may be the first point of entry to health services for women seeking pregnancy-related health care. As a primary caregiver, the midwife functions under her own responsibility. For each client, the midwife provides a continuum of midwifery services throughout pregnancy, labour and the postpartum period.

CONTINUITY OF CARE

Continuity of care is midwifery care provided in accordance with the standards of practice of the College and available during all trimesters of pregnancy, labour, birth and the postpartum period, on a 24-hour on-call basis. This principle is fundamental to the model of practice. Continuity of care is both a philosophy and a process that is facilitated through a partnership between a woman and her midwife/midwives. It requires a time commitment from each midwife that enables her:

- to develop a relationship with the woman during pregnancy;
- to be able to provide safe, individualised care;
- to support the woman during labour and birth; and
- to provide comprehensive care to the mother and newborn throughout the postpartum period.

Ideally, midwifery services will be provided by the same small group of midwives throughout pregnancy, labour, birth and the first six weeks postpartum. Family planning services may be provided up to three months postpartum. The full scope of midwifery care will be provided, including education, counselling, advocacy and emotional support.

Although continuity of care is usually facilitated by a one-to-one or a one-to-two relationship between a woman and her midwife/midwives, continuity of care can be achieved by a small group of no more than four midwives, as long as all members of the group share a common philosophy and a consistent approach to practice, and meet together regularly to co-ordinate care.[1] The woman must have the opportunity meet the midwives in the group before she goes into labour and to establish a relationship with the midwives providing her care.

One common way of providing continuity of care is in a shared-care team of two midwives who rotate responsibility for being first on-call. These two midwives may share responsibility for providing prenatal and postnatal care in addition to taking turns in being available to act as the principal midwife at the birth. The second midwife comes to assist near the time of delivery when the birth is occurring at home while in hospital the principal midwife is assisted by the

[1] The standard for continuity of care does not restrict the number of midwives who may work together in a practice or share a clinic space.

nursing staff. In a group of three or four midwives any one of the other midwives in the group may attend as the second midwife. However call schedules are arranged, the shared care team of midwives will ensure there is 24-hour on-call availability of one of the midwives known to the woman.

In situations where transfer of care to a physician is required during labour, the midwife is expected to continue providing supportive care after transfer and may resume primary care if appropriate. Supportive care involves education, counselling and advocacy throughout the course of care and also includes labour support and assistance with infant feeding.

Co-ordinating Continuity of Care in a Group Practice

Primary care responsibility may be shared by an on-call group of two to four midwives in a number of different ways, as long as a system is in place to ensure the coordination of each woman's and newborn's care.

This system must be documented as a practice protocol and must include:

- a way for current information on each client to be communicated to the the on-call midwife;
- regular review of each client's chart to ensure that an appropriate schedule of visits is maintained and clinical concerns are followed up in a timely manner; and
- a process for evaluating the system's effectiveness.

Midwives may create a variety of different systems to ensure effective coordination of care is achieved. Examples include: a) Assigning midwife to a co-ordinating role for each client and identifying this co-ordinating midwife to the woman and on the chart. In this system, the midwife fulfilling this role may change from time to time so long as the woman is informed and the change is charted; or b) Scheduling a regular weekly team meeting where the charts of all clients in care are reviewed; or c) Having the on-call midwife review all charts for issues needing follow-up when she takes over call.

INFORMED CHOICE

The College of Midwives' *Philosophy of Midwifery Care* states:

> "Midwifery promotes decision-making as a shared responsibility between the woman, her family (as defined by the woman) and her caregivers. Midwives recognise women as primary decision makers."

Midwives respect the right of women to make informed choices and facilitate this process by providing complete, relevant, objective information in a non-authoritarian, supportive manner. Having adequate time for discussion in the prenatal period is necessary to the successful facilitation of informed choice. Normally, antenatal and postnatal visits last approximately 45 minutes.

Midwives support the principle of informed choice by:

- promoting shared responsibility between the woman, her family and her caregivers and recognising and supporting the woman as the primary decision maker;
- encouraging women to participate actively in their care and to make choices about the services they will receive and the manner in which their care is provided;
- discussing the scope and limitations of midwifery care with the women in their care; and
- allowing adequate time for discussion in the prenatal period.

CHOICE OF BIRTH SETTING

Midwives respect the right of the woman to make an informed choice about the setting for birth. Midwives must be competent and willing to provide care in a variety of settings, including homes, hospitals and birth centres, where available. Midwives must have hospital privileges and be able to function within their full scope of practice in both the home and hospital setting. The ability to attend the woman in her choice of birth place is an essential aspect of continuity of care and informed choice. Midwives provide the information required to make an informed choice about appropriate settings in which to give birth. The birth setting is chosen by the woman in consultation with the midwife.

Establishing choice of birth setting as a fundamental component of midwifery practice is essential to providing women with equitable access to care in their chosen place of birth. This is particularly important in rural and remote communities where it is unlikely that women will have access to a choice of midwives.

SECOND MIDWIFE OR QUALIFIED BIRTH ATTENDANT

The Canadian standard of care is to have two skilled attendants at every birth. The safest care can be provided when there are two qualified persons present at a birth, each skilled in neonatal resuscitation and in managing maternal emergencies. Each birth, particularly those occurring in an out-of-hospital setting, should be planned with the understanding that two midwives will be in attendance.

When it is not possible to have a second midwife in attendance, reasonable efforts must be made by the principal midwife to secure the assistance of a suitably qualified second attendant prior to the birth. The second birth attendant must be skilled in neonatal resuscitation and in handling maternal emergencies.

Qualified second birth attendants may include registered nurses, physicians, or other health care practitioners who have the knowledge and skills required to assist the midwife with the birth, in accordance with the midwifery model of care. Arrangements for using a second birth attendant must be approved by the College.

COLLABORATIVE CARE

Midwives collaborate with other professionals to ensure their clients receive the best possible care. Collaborative care involves co-operation and consultation with other health care professionals in the provision of care. Collaboration with other health care providers occurs with informed choice and in the best interests of the woman and her newborn.

ACCOUNTABILITY AND EVIDENCE-INFORMED PRACTICE

Midwives' fundamental accountability is to the women in their care. They are also accountable to their peers, their regulatory body, the health agencies where they practise and to the public, for safe, competent, ethical practice, that is informed by the current research evidence in maternity care. Midwifery practice will incorporate evaluation that includes ongoing community input and participation in current mortality reporting standards and review processes. Results of these evaluations must be widely distributed to influence policy, education, and practice. Midwives will continue to develop and share midwifery knowledge, promoting and participating in research regarding midwifery outcomes.