ATTENDANCE AT AND RESOURCES FOR DELIVERY OF OPTIMAL MATERNITY CARE

SOGC CONSENSUS STATEMENT

UPDATED BY
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27TH ANNUAL RURAL & REMOTE MEDICINE COURSE
HALIFAX, APRIL 6, 2019

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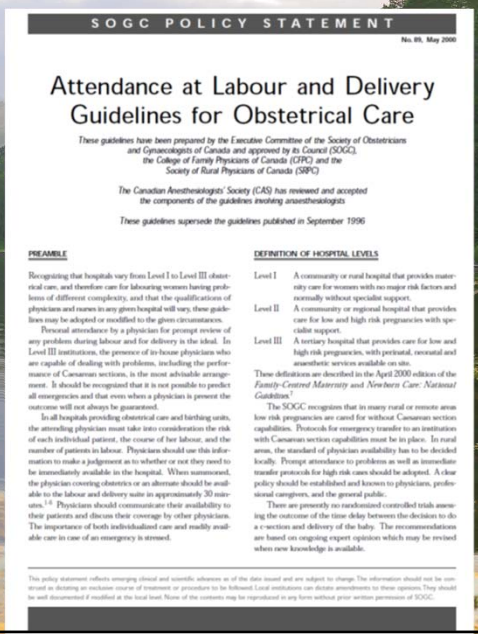
ORIGINAL DOCUMENT FROM MAY 2000



SOGC POLICY STATEMENT

No. 89, May 2000

Attendance at Labour and Delivery Guidelines for Obstetrical Care

These guidelines have been prepared by the Executive Committee of the Society of Obstetricians and Gynaecologists of Canada and approved by its Council (SOGC), the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC).

The Canadian Anesthesiologists' Society (CAS) has reviewed and accepted the components of the guidelines involving anaesthesiologists.

These guidelines supersede the guidelines published in September 1996.

PREAMBLE

Recognizing that hospitals vary from Level I to Level III obstetrical care, and therefore care for labouring women having problems of different complexity, and that the qualifications of physicians and nurses in any given hospital will vary, these guidelines may be adopted or modified to the given circumstances.

Personal attendance by a physician for prompt review of any problem during labour and for delivery is the ideal. In Level III institutions, the presence of in-house physicians who are capable of dealing with problems, including the performance of Caesarean sections, is the most advisable arrangement. It should be recognized that it is not possible to predict all emergencies and that even when a physician is present the outcome will not always be guaranteed.

In all hospitals providing obstetrical care and birthing units, the attending physician must take into consideration the risk of each individual patient, the course of her labour, and the number of patients in labour. Physicians should use this information to make a judgement as to whether or not they need to be immediately available in the hospital. When summoned, the physician covering obstetrics or an alternate should be available to the labour and delivery suite in approximately 30 minutes.[1,2] Physicians should communicate their availability to their patients and discuss their coverage by other physicians. The importance of both individualized care and readily available care in case of an emergency is stressed.

DEFINITION OF HOSPITAL LEVELS

Level I — A community or rural hospital that provides maternity care for women with no major risk factors and normally without specialist support.

Level II — A community or regional hospital that provides care for low and high risk pregnancies with specialist support.

Level III — A tertiary hospital that provides care for low and high risk pregnancies, with perinatal, neonatal and anaesthetic services available on site.

These definitions are described in the April 2000 edition of the *Family-Centred Maternity and Newborn Care: National Guidelines*.[3]

The SOGC recognizes that in many rural or remote areas low risk pregnancies are cared for without Caesarean section capabilities. Protocols for emergency transfer to an institution with Caesarean section capabilities must be in place. In rural areas, the standard of physician availability has to be decided locally. Prompt attendance to problems as well as immediate transfer protocols for high risk cases should be adopted. A clear policy should be established and known to physicians, professional caregivers, and the general public.

There are presently no randomized controlled trials assessing the outcome of the time delay between the decision to do a c-section and delivery of the baby. The recommendations are based on ongoing expert opinion which may be revised when new knowledge is available.

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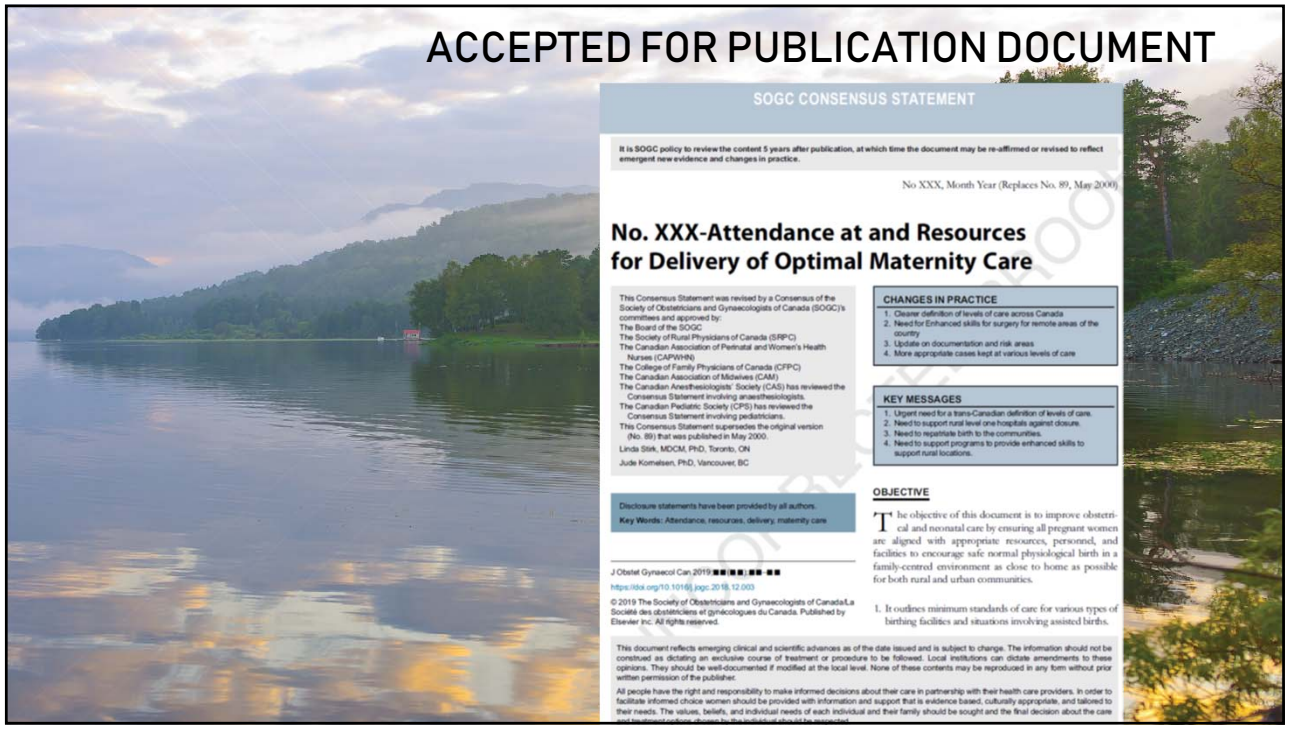
ACCEPTED FOR PUBLICATION DOCUMENT



SOGC CONSENSUS STATEMENT

It is SOGC policy to review the content 5 years after publication, at which time the document may be re-affirmed or revised to reflect emergent new evidence and changes in practice.

No XXX, Month Year (Replaces No. 89, May 2000)

No. XXX-Attendance at and Resources for Delivery of Optimal Maternity Care

This Consensus Statement was revised by a Consensus of the Society of Obstetricians and Gynaecologists of Canada (SOGC)'s committees and approved by:
The Board of the SOGC
The Society of Rural Physicians of Canada (SRPC)
The Canadian Association of Perinatal and Women's Health Nurses (CAPWHN)
The College of Family Physicians of Canada (CFPC)
The Canadian Association of Midwives (CAM)
The Canadian Anesthesiologists' Society (CAS) has reviewed the Consensus Statement involving anaesthesiologists.
The Canadian Pediatric Society (CPS) has reviewed the Consensus Statement involving pediatricians.
This Consensus Statement supersedes the original version (No. 89) that was published in May 2000.

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Disclosure statements have been provided by all authors.
Key Words: Attendance, resources, delivery, maternity care

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CHANGES IN PRACTICE
1. Clearer definition of levels of care across Canada
2. Need for Enhanced skills for surgery for remote areas of the country
3. Update on documentation and risk areas
4. More appropriate cases kept at various levels of care

KEY MESSAGES
1. Urgent need for a trans-Canadian definition of levels of care.
2. Need to support rural level one hospitals against closure.
3. Need to repatriate birth to the communities.
4. Need to support programs to provide enhanced skills to support rural locations.

OBJECTIVE

The objective of this document is to improve obstetrical and neonatal care by ensuring all pregnant women are aligned with appropriate resources, personnel, and facilities to encourage safe normal physiological birth in a family-centred environment as close to home as possible for both rural and urban communities.

1. It outlines minimum standards of care for various types of birthing facilities and situations involving assisted births.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well-documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the publisher.

All people have the right and responsibility to make informed decisions about their care in partnership with their health care providers. In order to facilitate informed choice women should be provided with information and support that is evidence based, culturally appropriate, and tailored to their needs. The values, beliefs, and individual needs of each individual and their family should be sought and the final decision about the care

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REVIEW PROCESS

- The Society of Rural Physicians of Canada (SRPC)
- The Canadian Association of Perinatal and Women's Health Nurses (CAPWHN)
- The College of Family Physicians of Canada (CFPC)
- The Canadian Association of Midwives (CAM)
- The Canadian Anesthesiologists' Society (CAS) – anesthetic data only
- The Canadian Pediatric Society (CPS) – pediatric data only

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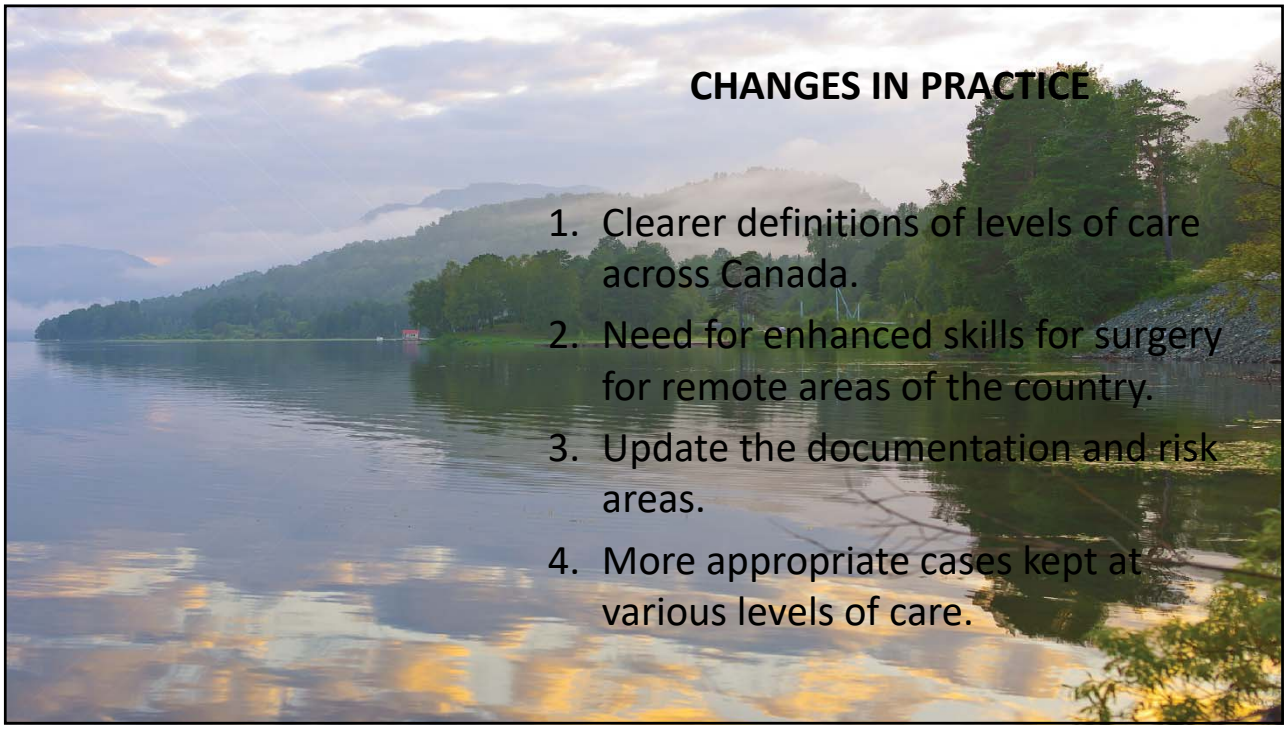
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SOGC RECOMMENDATIONS

- That Canada adopt one national standardized set of definitions to encompass all facilities providing maternity care for different levels of anticipated risk.
- That removing individuals from their community may have adverse social, economic and health outcomes.
- That women's autonomy is making informed decisions must be respected.

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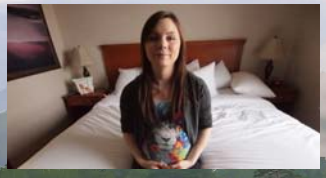
Pregnant women in rural B.C. urged to leave town to deliver



Briar Stewart
CBC News Feb 20, 2018

40% of women in rural Canada have to drive at least 1 hour away for maternity services

When she was eight months pregnant, Courtney Cornelius and her family drove 450 kilometres to Fort St. John, B.C., to give birth. Their community of Fort Nelson is one of dozens of rural communities where maternity services have been eliminated. (Briar Stewart/CBC)

For pregnant women in Fort Nelson, B.C., part of the prenatal routine includes agreeing not to have their babies in the northern community.

"Due to staffing issues, we are unable to conduct safe obstetric care," says the memo from the health centre.

An official with Northern Health, which oversees health centres in the region, says while physicians and staff are equipped to respond to an "unplanned delivery," women are advised to leave up to a month before their due date because "the safety of both the mother and the baby [are]

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TRANSPORT

- At the centre of the issue is not only transport, in a variety of weather conditions, but the willingness to **accept the transport** without questioning or refusal.

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CLEAR OBJECTIVE

- To align pregnant women with appropriate resources, personel, and facilities to encourage safe normal physiological birth in a family centred environment as close to home as possible, FOR BOTH RURAL AND URBAN COMMUNITIES.

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Uvamnik ihumagittiaqtunga
I Respect Myself
Je me respecte
Remember patient autonomy and keep families together.
Howa'a
Haida
Welálin
Mahsi' Cho
Gwich'in
Pinamaya
Nakota
Wneeweh
Mohawk
Nitsíniiyi'taki
Blackfoot
Guneshcheesh
Tlingit
Hay ce:p qa
Musqueam
Thank You
Meegwetch
Cree
Eeshneesh
Stony
Musicho
Déné
Hey chexw
Squamish
Kuksteme
Shuswap
Meegwetch
Ojibway
Yontonwe
Huron
Kwukstam'x kawx
Lil'Wat
T'ooyaksim nisim
Nisga'a
Wliwni
Abenaki
Yokoke
Choctow
Walus
Bella Bella
Kwas' H:oy
(Halq'emeylem)
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