

**Birth Options in Bermuda**  
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**BACKGROUND**

*“Midwife needed in Bermuda for 3 months...We used to have Midwives in our community but like everywhere else in the world, they have been replaced. We have 1 hospital which employs 18 CNM midwives but they can only practice as OB Nurses.” Email correspondence, Sophia Cannonier*

In October of 2008 an email made its way to my inbox: originally sent to the President of the Midwives Alliance of North America (MANA), it sought the services of a nurse-midwife to attend home births in Bermuda. Like many places around the world midwife-attended home births were the norm in Bermuda until the trend of treating childbirth as a medical event gradually moved laboring women into the hospital and under the management of physicians. This process was completed in the 1970’s and just as it had elsewhere, the relocation of birth occurred without midwives, who were neither credentialed nor licensed to practice in hospitals.

As a certified nurse-midwife who has practiced in the United States in birth center and hospital settings, I was intrigued by the email and its author, Sophia Cannonier, ex-ballerina, Pilates instructor, childbirth educator, certified doula, and native Bermudian. I learned that in the past four years there have been reports of couples choosing to have unattended home births rather than to give birth in the hospital. Accurate information about these births has been difficult to ascertain, chiefly due to a widespread belief that home birth is illegal. While this is not true, the lack of access to licensed professionals willing to attend births outside the hospital gives women little choice in birth settings. Sophia herself delivered her first child without professional assistance in 2004, but as her role as doula and childbirth educator evolved into her life’s work she came to the conclusion that keeping home birth “underground” would not foster the change she and her clients so desired to Bermuda’s maternity care system. Using her personal experience as a catalyst, in 2007 she employed a different strategy: a friend from childhood working as a nurse midwife in England agreed to return to Bermuda to attend the home birth of Sophia’s second child. The resulting publicity surrounding this event and Sophia’s near missionary zeal to promote birth options created a swirl of controversy over this fishhook-shaped island surrounded by the blue waters of the Atlantic Ocean.

Thus it was into this storm that I found myself drawn as I began correspondence with Sophia and with a couple requesting my services for the home birth of their first child due in January. We simultaneously began to work out the logistics of bringing me to the island and completing my application for registry as a midwife under Bermudian law. A local family practice physician fulfilled the required role of “sanctioning” physician while the organization that houses Sophia’s classes submitted an application for a temporary work permit.

In addition to clinical services I agreed to make myself available for meetings with various parties to discuss concerns surrounding birth options. The goal was to shed light on the conditions that lead couples to make less than safe birth choices such as unattended home births. Perhaps an outsider’s perspective would encourage the dialogue

needed to overcome the polarization and passion that recent events have sparked. In the three weeks that I visited the island, I met with many of the stakeholders: childbirth educators and doulas, hospital midwives, obstetricians and administrators, officials and staff from the Ministry of Health, insurance industry representatives, the midwife who delivered Sophia's baby, and consumers of maternity care.

My aim is to provide an overview of the issues of concern, and my hope is that this document will be a step toward the goal of protecting the health of mothers and newborns while promoting positive birth experiences for families in Bermuda. I believe that solutions can be found providing that good will and trust exists among those parties concerned with maternity care in Bermuda.

## THE CHILDBEARING POPULATION AND MATERNITY CARE IN BERMUDA

*Bermuda enjoys the third highest per capita income in the world, more than 50% higher than that of the US. Its economy is primarily based on providing financial services for international business and luxury facilities for tourists. CIA-The World Factbook*

**T**hough Bermuda is a British protectorate, the island's medical infrastructure is modeled on the United States. Perhaps because obstetricians are largely recruited from the US, they tend to follow the standards set by the professional body based there, the American College of Obstetricians and Gynecologists (ACOG). Financing of maternity care is similar as well to the US; those with health insurance typically see private obstetricians while those with limited financial resources or no health insurance are seen by physicians employed by the Ministry of Health's Maternal Health & Family Planning Clinic.

Currently, three obstetricians serve the childbearing needs of the island's 65,000 residents, delivering approximately 800 babies a year in the island's sole hospital, King Edward VII Memorial Hospital. Physician staffing for the hospital has declined in recent months, attributed to normal attrition and the rising cost of obstetrical malpractice insurance. An active effort to recruit more obstetricians to the island is likely to result in two more physicians joining the work pool by the fall of 2009.

## MIDWIFERY IN BERMUDA – AN ISLAND BETWEEN TWO COUNTRIES AND TRADITIONS

**T**oday the hospital in Bermuda recruits nurse midwives from around the world to work on the maternity ward yet upon accepting employment they are contractually obligated to limit their practice to obstetrical nursing. This creates the interesting paradox that while nurses are not eligible to work on the unit without midwifery credentials, a midwife works on the ward not as a midwife but as a nurse, acting as assistant to the physician.

This model is not commonly found in either the US or the UK. ACOG and the American College of Nurse-Midwives (ACNM) have long held a "Joint Statement of Practice Relations" meant to support areas of interface between the two professions<sup>1</sup>; collaborative agreements between physicians and midwives are routine. However, areas of disagreement between the two bodies do exist. In the document *Position Statement: Home Birth*, ACNM outlines its support for home birth and publishes a handbook that

addresses selection criteria, mechanisms for consultation and transfer, and the establishment of quality management systems.<sup>2</sup> By contrast, ACOG has adopted an official stance of opposition to home birth,<sup>3,4</sup> a departure from their counterparts in the UK, where a long tradition of home birth is supported within a national framework of comprehensive maternity care.<sup>5</sup> The National Health Service in the UK includes an initiative by the British government to utilize the model of “midwifery-led” primary care that was recently supported by the Cochrane review.<sup>6</sup>

Under the Bermuda Midwifery Act of 1949, a mechanism exists for registry whereby midwives might practice with some degree of autonomy but it has rarely been used in recent years.<sup>7</sup> As outlined in the Act, midwives must be registered nurses and pass a test administered by the Ministry of Health. In addition to the midwife who attended Sophia Cannonier’s birth, my application stands as only the second by a midwife whose intention is to offer home birth services.

### THE CONSUMER’S PERSPECTIVE

*“The midwife insisted that I lie down so that she could put the monitors on me. I did try, but the contractions were so strong. I did ask her to put them on me whilst I was standing up - but she refused. She tried to blackmail us saying that I was putting the baby at risk!! However, my body said I had to push, and so I did what nature intended. 2 or 3 contractions later the head crowned. I put my hand down and felt the head and got told off by the midwife - again stating that I was putting the baby at risk (of what I am not sure)... She was born a few minutes later. The doctor arrived a few minutes after that... We were in the hospital building for a total of 19 minutes from door to delivery. The best way ever! No meds, no intervention, and no listening to the midwife who seemed to want to extend the pain rather than helping.”*  
*Emailed birth story of woman delivering in King Edward Memorial VII Hospital, Bermuda*

Stories such as the one above illustrate the difficulties women have if they desire more control and a less medical approach toward delivering their babies. Although the end of the story has the woman assessing her birth in a positive light (“the best way ever!”), her description of the experience would strike many as chaotic, if not traumatic. Her arrival to the hospital in an advanced state of labor seems a deliberate attempt to avoid contact with the hospital for as long as possible. The dream of a peaceful, joyous welcome to the world for her newborn is replaced by a sense of accomplishment and empowerment for having prevailed in the face of strife and conflict. Given the choice, one wonders which experience she would have preferred.

While on the island my interviews with several expecting families shed additional light on the perspective of childbearing women. While expressing confidence in their obstetrician’s technical skill and competency, they desire more time with their provider during antenatal visits and more control over their experience in labor and birth. Their concerns are not unique; in a world where normal, or what has been dubbed “physiologic” birth is losing ground, women who desire something other than the usual care have resorted to various coping mechanisms – and for some, home birth is a last resort. A valuable resource for understanding the desires and concerns of childbearing women is the excellent set of surveys conducted in the US from 2002 to 2008, the *Listening to Mothers* survey. According to this document, women want care that

involves them in decision-making; care that is flexible and responsive to their individual situations; care that avoids unnecessary interventions such as induction for non-medical reasons, routine artificial rupture of membranes and continuous fetal monitoring; and care that gives them access to non-pharmaceutical methods of pain relief, such as hydrotherapy.<sup>8</sup>

How does a family arrive at the decision that home birth is their best option, especially in Bermuda where there are few or no licensed health care practitioners to provide this care? A typical scenario begins as it does for many prospective parents, with registration for prenatal and childbirth classes. Attended by first timers as well as experienced mothers, this step marks the beginning of a sort of “consciousness raising”, as discussion about maternity ward policies and how to handle potential scenarios of labor and birth dominate the discussion. For example, during the classes I attended, a subject given particular attention was how to avoid being given drugs to induce or speed up labor such as when pregnancy extends beyond the due date or when membranes rupture before active labor. For some women, fear that medical procedures will be foisted upon them reaches fever pitch by pregnancy's end; once the baby arrives war stories shared among classmates often validate and further the sense of mistrust. The desire to avoid such intervention may lead women to stay at home in labor longer than is optimal, thereby causing safety concerns associated with transport to the hospital.

Some choose to hire doulas, typically women trained to offer labor support and to assist families as they navigate the health care system. Described as a “distinctly American creation”, the doula is a “product of medicalized birth, a response to it.”<sup>9</sup> Historically doulas took care of household chores and younger children along with providing comfort measures in labor. Today, she has an additional role as consumer protector and advocate, placing her in the difficult position of supporting the client’s wishes while retaining good relations with the medical team, for without recognized medical credentials she has no absolute right to be in the delivery room. While I found no evidence that doulas are in danger of being banished from the maternity ward, concern was expressed among hospital personnel (doctors, midwives, and administrators) that doulas have at times overstepped their role by advising their clients on medical matters. Though certainly not the majority opinion, there was also concern that doulas and childbirth educators can interfere with the relationship between health care provider and patient and contribute to a contentious atmosphere where patients view every procedure with suspicion.

When birth becomes a battleground, some families decide to opt out by birthing outside the system. But this choice is not feasible for most women, for even if a qualified attendant can be found there is the additional expense of paying the fee of that attendant. And on an island as small as Bermuda where news of a family making such an unusual choice travels fast, the issue of privacy becomes a concern: as one woman told me, “I don't want my birth to become a political act.”

#### SAFE AND SATISFYING BIRTH – CLOSING THE GAP

*“Consensus definition of “safe childbirth” should be sought. The definition should include having a positive, non-traumatic birth experience.” Fiona Dill, Nurse Childbirth Educator and Doula, Bermuda*

In response to the publicity surrounding home births, in August 2008 Cheryl Peek-Ball, Medical Officer for the Maternal Health & Family Planning Clinic, compiled the report *One Common Goal, Many Perspectives* in which she spoke with physicians, childbirth educators and public health officials. Representing an important step in dialogue among the key players involved in the controversy, certain themes emerge that deserve further examination:

1. Women have the right to informed choice regarding their delivery environment.
2. Childbirth should be deinstitutionalized in properly staffed birthing centers.
3. Bermuda's laws regulating midwifery should be revised using successful models already developed, such as in the UK and Canada.

Concerning the first statement, there is only one choice for women regarding their delivery environment if they desire access to credentialed personnel, and that is to birth in the hospital. Therefore it would seem that the most expeditious solution to improving women's experiences is to make changes in this environment. And although KEMH is scheduled for renovation in the future, a careful review of what consumers want reveals that hammers and nails are not so necessary as a change in attitude, for example, using a less medical model of birth and providing more flexibility towards the needs and desires of individual patients and their families.

The second statement that birthing centers are an acceptable alternative to the hospital requires clarification as to what is meant by "birthing centers". Birth centers are yet another uniquely American invention and, like doulas, were born out of reaction to the consumers request that childbirth be managed in a more family-oriented manner.<sup>10</sup> But in the US the phrase "birth center" refers to in-hospital as well as out-of-hospital or freestanding facilities, some of which are located as far away as thirty minutes from a hospital. More discussion is needed to develop consensus on what would constitute an acceptable birth center setting and the personnel that would meet the definition "properly staffed".

Finally, as suggested in item three, a careful review of midwifery models in the UK and Canada is in order, but it seems prudent to include a review of the US model as well, since physicians working in Bermuda are recruited from all three countries.

## RECOMMENDATIONS

The following recommendations are made with the knowledge that no one person has all the answers; answers emerge from the well-intentioned and good faith efforts to include input from all stakeholders.

1. **Re-examine the hospital's current utilization of midwives as obstetrical nurses:** In an environment where staffing issues involve considerable efforts at recruitment and retention, this pool of talent represents a resource that is readily available, consumer-friendly, and economically efficient.
2. **Review the regulation of midwifery:** The requirement that the profession of midwifery be linked to nursing seems particularly onerous on an island that offers education programs in neither discipline. Currently the US and the UK are

- reconsidering the requirement that midwives be nurses, while the Canadian model has incorporated so-called “direct-entry” midwives with great success.<sup>11</sup>
3. **Revise hospital routines and procedures:** Some of the impetus of consumers choosing home birth appears to be driven by factors that are tangible and relatively easily remedied, such as,
    - a. The use of hydrotherapy via birth pools (or simply bath tubs).
    - b. A review of policies that may impede family-centered care, such as restrictive visiting policies.
    - c. Provision of a “normal birth room” where midwives attend the births of appropriately selected women, the use of electronic fetal monitors is prohibited, and birth is allowed to proceed according to its own timetable. Such a measure might satisfy consumer needs while providing opportunities to train and update the existing work force, i.e., midwives, as well as affording an opportunity for other medical personnel to learn the characteristics of normal, undisturbed birth.
  4. **Provide a framework for alternative birth options, providers and settings:** As stressed by the Public Health perspective (Department of Health) in the *One Common Goal, Many Perspectives* document, there must be minimal infrastructure requirements for safe home birth, including "transparent collaborative antenatal care by birth attendant and relevant healthcare professionals", an agreed upon set of guidelines for all attendants and a system for emergency referral and transfer.
  5. **Review care given using the growing body of systemic reviews:** The field of pregnancy and childbirth pioneered the use of evidence-based practice, yet maternity health care continues to produce large expenditures with mediocre results. An excellent resource in understanding the impact of care practices and the multi-dimensional aspects of implementing research-based care is the landmark document “Evidence-Based Maternity Care: What It Is and What It Can Achieve”.<sup>12</sup> A symposium in Washington, DC on April 3, 2009 will produce a Blueprint for Action.

## CONCLUSION

A partnership of health care professionals and public and private organizations should be organized to examine maternity care in Bermuda. Representation of all those interested in maternity care is critical in order to achieve a shared vision. Such an effort requires considerable leadership, resources and good will among the many stakeholders. The hard work of achieving consensus will be rewarded by a uniquely Bermudian solution, one that is comprehensive, serves the needs of the public, and is integrated into the island’s health care system.

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<sup>2</sup> American College of Nurse-Midwives. (2005). *Position Statement Home Birth*. <http://www.midwife.org/siteFiles/position/homeBirth.pdf> [accessed March 4, 2009]

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