

July 21, 2008

Ms. Annie Schiefer  
Health Professionals Regulatory Advisory Council  
55 St. Clair Avenue West  
Suite 806, Box 18  
Toronto ON M4V 2Y7

Dear Ms. Schiefer:

Attached please find the Ontario Medical Association's (OMA) comments upon the College of Midwives of Ontario's (CMO) proposed changes to the *Midwifery Act*, its regulations and related legislation.

The OMA is committed to working together to improve care and address the barriers to interprofessional collaboration in perinatal care settings. However, the OMA stresses the importance of patient safety in addressing midwives' scope of practice. As you will see from our response, the OMA is concerned about the impact the CMO's proposed changes will have on the quality of care provided to mothers and newborns. The OMA emphasizes the importance of both training and ongoing skills maintenance in handling complex pregnancies and births.

We hope HPRAC will include the OMA's views in the preliminary review of the proposed regulatory changes to the midwifery scope of practice. We look forward to participating in dialogue on this important issue.

Sincerely,

A handwritten signature in black ink that reads "Ken Arnold". The signature is written in a cursive, slightly slanted style.

Ken Arnold MB BCh  
President



## **ONTARIO MEDICAL ASSOCIATION**

Submission to the Health Professions Regulatory  
Advisory Council  
Respecting  
Issues Related to Midwifery Scope of Practice

July 2008

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## **Introduction**

The Ontario Medical Association takes this opportunity to comment on the College of Midwives of Ontario's (CMO) proposed changes to the current midwifery scope of practice. The OMA is committed to assisting in developing constructive dialogue on the issue of interprofessional care and increased access to care.

While the OMA agrees that there may be room to expand the collaborative arena between obstetricians, gynecologists, family practitioners, midwives and other care providers, the OMA believes that such changes must ensure patient safety. The OMA is concerned that the changes to midwives' scope of practice proposed by the CMO do not fully consider the academic and technical training as well as the practice experience that dictate the legitimate boundaries of midwives' scope of practice.

In its submission, the CMO indicates that in order for a midwife to perform certain procedures, a midwife should be allowed to hold a position in an "extended" practice class. We submit that while midwifery represents a very useful human resource in reproductive care, it is important that midwives operate within an appropriate course of care. The CMO's suggestions do not often address the need for flexibility within the CMO's *existing* scope of practice. Rather than fully exploring ways to optimize their current scope of practice, the CMO seeks to step outside of its intended role and into the field that should be managed by physicians and medical teams in response to the acuity of care required.

It should be noted that the number of births handled by midwives in Ontario is relatively low compared to the number of deliveries performed by obstetricians. In its February 2008 Report: Ontario Medical Association Policy on Maternal and Newborn Care, the OMA noted that in 2003 over 80% of women were attended by an obstetrician; 11% by a GP; 3.5% by a midwife in hospital, and the balance by a midwife at home or by other providers. The Perinatal Partnership Program for Eastern and Southeastern Ontario

(PPESO) indicates a continuing trend in 2006 when 86% of birth care was delivered by an obstetrician; 9% by a GP; and 4% by a midwife.<sup>1</sup> These statistics indicate that midwives handle few complex cases – this is owing to their practice philosophy and scope of practice. This scenario results in midwives having limited ongoing exposure to higher-risk pregnancies and an inability to ensure skills maintenance in this area.

While we will address our specific concerns related to the details of the CMO's submission, we wish to make a few general comments. These concerns are related to the CMO's scope of practice review but speak more broadly to the ongoing discussion of expanding and changing scopes of practice.

- 1. Focus on Current Scope of Practice.** Midwives are registered health professionals who manage low-risk pregnancies, labour and births at home and in hospitals. The CMO focuses on expanding scopes of practice either through developing existing controlled acts or adding new acts to the midwifery repertoire. Some of the suggestions are appropriate and will function along a medicine-midwifery continuum of care. However, the OMA strongly believes that the most useful approach to improving interprofessional collaboration is to assist midwives (and all health professionals) in fulfilling their current scope of practice to the fullest extent.
- 2. Training and Education.** The level of training required for many of the expanded and additional controlled acts mentioned by the CMO is tantamount to that required by physicians practicing obstetrics. In many cases, there is little rationale for including new controlled acts given that the scope of midwifery is specific to normal, low-risk pregnancies and the training for this group is limited to the acts required to support childbirth as a “natural process”.
- 3. Clarity in Purpose of Review.** It is the OMA's understanding that the HPRAC review project has, as its goal, improving quality patient care in a collaborative

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<sup>1</sup> Details of PPESO Report available at: <http://www.ppeso.on.ca/english/niday.html>.

environment. However, it appears that the CMO's proposed changes may inadvertently cause further fractionation instead of integrating care. Certain pregnancies demand physician attention and management of these complex cases should not be delayed or undermined because of practitioners' unwillingness to share care or refer.

4. **Referrals to physicians.** The OMA is concerned that many of the procedures the CMO seeks to have included within its scope actually represent medical emergencies. Several of the acts mentioned in the CMO's submission are performed when there is an underlying medical condition with the pregnancy. When less frequent obstetrical procedures are required or particular medications needed, physicians should be managing the pregnancy. Referral to a physician at a late point in a pregnancy (especially if an emergency arises) is inappropriate and avoidable. There is unnecessary risk exposure for patients and professionals associated with these types of late referrals.

### **CMO's Proposed Changes to Midwives' Scope of Practice**

In some cases, women choose the services of midwives instead of traditional medical and obstetrical care. Midwives give prenatal care to expectant mothers, attend the birth of the infant, and provide postpartum care. Midwives undergo technical training to perform a *defined* set of prenatal, labour and post-labour procedures. However, there are a number of obstetrical maneuvers that are not within the midwife repertoire - typically because they pose a risk to mother and/or child and require the more specialized and technical care of a physician.

The CMO provides suggestions to HPRAC on possible amendments to the *Midwifery Act, Regulated Health Professionals Act* and associated regulations. The CMO asserts that these changes will ensure the following:

- Improve interprofessional care and collaboration

- Increase medical care to underserviced areas.
- Integrate midwifery in the patient care model

On the first point, it should be noted that enhancing interprofessional collaboration is a substantive endeavor that requires in depth analysis and understanding of the current roles and *limitations* of all health professionals. The CMO proposal fails to address the two key issues that the OMA believes undermine collaboration:

- (1) The fact that shared care is not permitted except upon special approval by the CMO and;
- (2) That the midwifery payment model penalizes midwives who refer care to physicians in mid-course.

Next, while improving care to underserviced areas is an important goal of this process, it is equally important that the public have access to *safe* obstetrical care. A lack of physicians in rural areas should not result in patients receiving care from practitioners whose training and/or experience is not suitable for the acuity of care required.

On the third point, the OMA fully supports an integrated provincial model for maternal and newborn care and has called upon the provincial government to take a lead on this initiative (June 2008). We will now discuss the specific proposed amendments.

### **Revision to Scope of Practice**

#### **Well-woman/Well-baby Exams**

The CMO proposes revisions to the scope of practice statement under the *Midwifery Act*. Specifically, the CMO would like to see midwives perform well-woman, well-baby care beyond the 6 week period. The OMA has major concerns with the proposal to extend well-baby care beyond the age of 6 weeks. Pediatricians have seen a significant number of missed diagnoses such as heart murmurs, genetic syndromes and physical

abnormalities in midwife referral cases. While a “checklist” such as a Rourke Record may be relied upon to validate child care, thorough assessment of newborns and babies requires more than this and involves a combination of family history and physical examination. Appropriate health care for newborns and babies requires training and clinical experience beyond that contained within the midwives’ scope.

With growing emphasis on preventive care, there is a need for accuracy in recognizing disorders of development, growth and nutrition.

### **Pre-conception counseling**

It is the OMA’s position that this type of counseling should only be undertaken by an individual with the appropriate knowledge of the range of issues associated with conception. Midwives must demonstrate that they have an appropriate level of expertise in psychology, medicine, genetics and other fields before undertaking pre-conception counseling. The details of this extended role need to be clarified ahead of any action on this issue.

### **Non-Spontaneous Normal Vaginal Deliveries**

The CMO proposes removing the word “spontaneous” which currently outlines midwives parameters for vaginal births. There is no indication that having midwives work in this area is necessary or even safe. Non-spontaneous vaginal births may result in the need for emergency Cesarean-sections and should not be performed outside of a hospital setting where an obstetrician and anesthesiologist are on site. Any act that accelerates labour and transforms it into a non-spontaneous birth may have complications. It is debatable as to whether or not induced delivery (with the use of prostaglandins, oxytocics or ARM for example) can still be categorized as “normal”. This depends on the types of medications used in this process as well as their side effects on newborns, mothers and postpartum activities like breastfeeding.

### **Clarification of Activities within Current Authorized Acts**

### **Manual Removal of Placenta: Beyond Labia**

This procedure is considered risky by obstetricians. There is an increased risk of infection as well as the possibility of portions of the placenta being left behind. Furthermore, the need to perform a manual removal of placenta often signals a complication which increases the risk to the mother. A case requiring manual removal of placenta may indicate that there is already a physical issue that demands surgical skills. Even in a hospital setting with an obstetrical team, accreta that may occur as a result of this process can be fatal for the mother. Post-partum hemorrhaging associated with manual removal of placenta is one of the leading causes of maternal death in Canada.

### **Vacuum Assisted birth**

In most cases, a vacuum extractor is used to avoid a cesarean section or to prevent fetal distress. When used properly, the risks of vacuum-assisted vaginal deliveries are far fewer than the risks of cesarean section or prolonged fetal distress. Thus, when the vacuum is used properly, it may reduce risks significantly to both mother and baby.

Nevertheless, the complications of the procedure have been well-documented and range from mild cosmetic changes of the scalp to hematomas and more serious problems like neonatal jaundice, intracranial hemorrhaging and retinal hemorrhaging. The SOGC provides detailed guidelines on performing these vacuum assisted deliveries beyond the labia.<sup>2</sup> If there is inadequate progression of birth, a midwife should consult a physician.

### **Expansion of Current Authorized Acts**

Expanding midwives' scope to include **scalp clip beyond dermis** is reasonable since this is a rather benign procedure. In cases where Doptone monitoring gives a poor recording of the fetal pulse, applying a scalp monitor is good practice and should be permitted. However, when required, a scalp clip may be an indication that higher level care is required in which case an immediate referral to a physician should be made.

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<sup>2</sup> We would refer to the SOGC Policy Statement, No. 89, May 2000. Available at [www.sogc.org](http://www.sogc.org)

The OMA strongly opposes midwives applying **scalp Ph beyond dermis** as this is considered a very high risk procedure for physicians.

The OMA does not support the expansion of midwives' current authorized acts to include either **taking blood from fathers or donors**. Analysis of blood types and blood-related illnesses should be properly screened by physician clinicians and hematologists. The OMA believes that the CMO should clarify the purpose of this expanded practice before proceeding to a discussion on it.

### **Addition of Controlled Acts**

The CMO suggests that **intubation** beyond the larynx should be an act midwives are sanctioned to perform. This procedure is technically difficult and requires specialized training that physicians and certain emergency personnel possess. Midwives should not be able to self-identify their expertise in this area but must be certified in Neonatal Resuscitation (NRP). Even with this certification, this procedure should only be performed by midwives when there is no immediate medical help available and the infant is at risk of dying. In order to allow a health professional to perform this procedure, it really must be clear that he or she possesses the requisite skill sets and competencies achieved through training and volume of intubation cases handled.

From a pediatric care perspective, there are other concerns with the CMO's suggestions relating to neonatal care. While it is arguable that extended care RN and RT on Transport Teams enjoy some form of these privileges, there are strict guidelines in place for training, experience and supervision that ensure safety and appropriate care of the newborn. As with any resuscitation, ongoing care to ensure a minimum of morbidity and mortality requires not only technical training, but also an ability to apply medical knowledge and management in complex, changing clinical settings. Beyond "drawing blood gases" and "intubating", the newborn must be monitored, assessed and reassessed

for proper ventilation, fluid resuscitation and other interventions. This is beyond the parameters of a “natural process”.

Allowing midwives to administer medications in **suppository** form may be appropriate if the medications are already managed within their scope of practice. For example, administering Misoprostol to decrease post-partum hemorrhaging and stabilize the patient until medical care is available may be within a midwife’s scope. However, obstetrical knowledge dictates that the need for a drug like Misoprostol indicates a medical problem that should be handled in a hospital by a physician.

**Umbilical catheterization** is a central line placement, and if improperly done, can have disastrous consequences including death of the newborn. Again, this issue is centered upon patient safety and without the proven skill set, midwives should not be allowed to perform it.

Due to the many risk factors associated with repairing **third and fourth degree perineal tears** midwives should not perform these procedures. To prevent women from having long-term sequelae due to third-degree tears, avoidable risk factors should be minimized whenever possible and physicians are in the best position to make these assessments. Because of the severe complications associated with improper repairs and the risk of developing fistulas, this procedure should be performed by an individual with appropriate medical training in a hospital. The use of a midline episiotomy has been associated with increased risk of severe anal sphincter tears and fourth degree tears in particular involve repair of rectal mucosa. A failed repair or a poor repair may result in a Colostomy and other needs such as a further repair at a later date. The average obstetrician does very few of these challenging repairs in the course of a year. Obviously, a skill set would have to be maintained in this area. Further, these repairs usually require an anesthetic and require many of the tools and medical personnel present in an OR.

In the very rare event of a third or fourth degree tear in an underserviced community, homeostasis is a primary concern. Achieving homeostasis could be established with identification of the bleeding vessels, but the patient would then be transferred to another community with the required surgical expertise in repairs.

It would be a contra-indication to attempt a third or fourth degree repair in a home birth scenario. Again, haemostatic priorities are primary for the care provider on site, but the actual layered repair and post-operative management would be, for the benefit of the patient, best provided by someone with ongoing experience and expertise.

### **Medications**

Drugs such as oxytocics, narcotics and antibiotics should be prescribed by a physician. The risks associated with over-prescribing, adverse drug interactions and drug side-effects are all reasons why prescribing certain drugs is beyond midwifery training.

In the case of lab requisitions and tests, midwives should operate within the same limiting parameters as any family practitioner working in a hospital where there are consultant obstetricians. However, the OMA stresses the importance of medical consultation and treatment of suspected or existent UTIs or STIs.

The OMA believes that MMR vaccines should be handled by family physicians to ensure continuity of care. The OMA is also inclined to limit Varicelle immunoglobulin exposures to family physicians. There is little to suggest that allowing midwives to administer vaccines will improve interprofessional care as it erodes the children's health care model that includes physicians, public health nurses, nurse practitioners and others. Family practice is based on the premise of whole-patient, whole-life care and it appears that the midwifery proposal would result in fragmented, not integrated care.

### **Lab Tests**

A call for certain medications and lab tests may indicate a more serious underlying condition that requires medical attention. Therefore, the CMO's request to amend the

*Laboratory and Specimen Collection Centre Licensing Act* to allow for Pregnancy Induced Hypertension (PIH) blood work is problematic if the proposed change is not worded with extreme clarity. Midwives are currently not authorized to handle PIH bloodwork in their scope of practice because this test may foretell a serious medical complication during labour. It is true that allowing midwives to order PIH tests would reduce the delay in obtaining results. This expansion in scope is acceptable if it is qualified with a requirement that such an order necessitates immediate referral to a specialist.

**Cord blood gases** are routinely taken by Labour Room nurses in many deliveries and can be useful if a subsequent problem arises with the fetus or for future medico-legal purposes. We see no reason to restrict this activity.

### **Ambulance Act**

The OMA has concerns with respect to amending the provision in the *Ambulance Act* that will allow midwives to direct ambulances to hospitals where privileges are held. Any mother or newborn requiring further care or monitoring should be directed to the hospital most appropriate for their care. It is absolutely inappropriate to place a practitioner's wishes above the medical needs of the patient.

### **Conclusion**

Midwives are valuable players in the field of low-risk maternal and new-born care and we are committed to working together to improve care and address the barriers to effective interprofessional collaboration.

As we have discussed, a number of the proposed changes to midwives' scope of practice are useful amendments. On the other hand, some requests appear to position midwives as physician substitutes without full recognition of the extensive and comprehensive training that family physicians and obstetricians undertake. The OMA stresses quality of care as the priority as we work to promote integrated models of perinatal care.