RYERSON UNIVERSITY

April 10, 2008

Ms. Anne Schiefer
Health Professions Regulatory Advisory Council
55 St. Clair Avenue West.
Suite 806, Box 18
Toronto, Ontario

Dear Ms. Schiefer,

Thank-you for the opportunity to respond to the College of Midwives of Ontario's (CMO) proposed changes to the Midwifery Act and the related regulations.

My response is in three parts. I am responding on behalf of the Ryerson University Midwifery Education Program (MEP), as Acting Director and as a faculty member since the inception of the program in 1993. I would also like to provide a response based on my experience as co-chair of the Ontario Maternity Care Expert Panel, an interdisciplinary group convened by the Ontario Women's Health Council to advise the Ministry of Health and Long Term Care on maternity care issues. Finally, I would also like to add comments as a practicing midwife with 28 years of experience working both prior to the legal recognition of midwifery in Ontario and as a Registered Midwife since 1994. As a midwife, I work both in the tertiary care setting of Mount Sinai Hospital in Toronto and in Nunavik, the remote Inuit region of northern Quebec.

Some of my comments will also respond the OMA's submission to HPRAC.

I would like to express appreciation for HPRAC's work on this important matter. A review of midwifery scope and regulations is an important opportunity to bring the legal framework for midwifery up-to-date and allow the profession to respond to changing evidence and provide the safest possible care to women, newborns and their families throughout the province.

Sincerely,

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Response to the College of Midwives of Ontario Proposal on the Midwifery Scope of Practice from the Ryerson University Midwifery Education Program

As one of the three university sites of the Ontario Midwifery Education Program Consortium, Ryerson University midwifery faculty members support the changes put forward by the CMO. As educators, we can comment on the capacity of the educational institutions to provide the academic education and clinical experience required. The program is currently well placed to adapt its curriculum as we are engaging in an extensive process of curriculum revision after expansion of the program was announced in September 2007. We can also comment on the need to make these changes to the midwifery scope in order for the profession to provide the safest and most effective care to the women and babies under the care of midwives. Adoption of the CMO's proposed changes would support best practice and therefore optimal settings for the education of midwives, by clarifying and facilitating full scope and evidence based practice and therefore providing more consistent experience for students in their clinical placements.

The majority of the changes proposed by the CMO are clarifications of areas of scope that are well covered by the current MEP curriculum, as the activities are part of normal practice for many midwives in the province and have been part of the curriculum since its inception. These areas include induction and augmentation of labour both by artificial rupture of membranes and by pharmacologic means; providing care and monitoring when women have epidural analgesia; emergency management of postpartum hemorrhage including manual removal of the placenta in the absence of medical help. All of these areas are covered in our curriculum, through both academic learning in problem based tutorials; via hands on workshops; interdisciplinary lectures and in clinical placements. Clinical placements include those with midwives (5-6 terms with midwives working in clinics, homes and hospital). Third year placements (previously one term and now two terms) include nurses, obstetricians, pediatricians and/or respiratory therapists. Key objectives for these placements include providing care for women and babies whose care involves interventions. Some of these areas, such as induction, augmentation and epidural analgesia have been strengthened within the MEP curriculum over the past five years, in recognition that students who work in areas where midwives practice is restricted many need additional teaching provided by the program. The MEP asks all midwifery clinical teachers to ensure students have adequate exposure to these areas even if the local hospital requires transfer of care to medicine and nursing when midwifery clients require these interventions. The midwifery student continues as a learner involved with the woman's care, taught after transfer by other members of the health care team as well as her midwife preceptor.

As I understand the CMO's proposal, removing the words spontaneous and normal from the definitions of midwifery scope does not mean that midwives would change their focus on childbirth as a normal healthy process. Midwives would continue to consult and refer as described in CMO standards i.e. for postdates pregnancy and prolonged labour for example. The rationale to remove these terms is that it would clarify that it is still

appropriate for midwives to provide primary care to women whose labours are induced or augmented and therefore remove barriers in some institutions.

Neonatal umbilical vein catheterization and intubation are covered through mandatory student certification in the Neonatal Resuscitation Program (1x per year beginning in the 2nd year of the program). This requirement for yearly certification is part of maintaining registration with the CMO for all practicing midwives and it is worth noting that this requirement is more rigorous than the standard for most professionals, which is 2x per year. Emergency neonatal skills such as this are not anticipated to be used in settings where there is access to either respiratory technologists or pediatric specialists within a reasonable time frame. However it makes sense to allow those midwives who are working in settings where they may be the most responsible care provider present in an emergency or the most skilled team member to develop and maintain these skills.

Emergency skills such as manual removal of the placenta, vacuum delivery and extended practice including cesarean section assist or repair of 3rd or 4th degree tears are potentially very important to midwives working in rural and remote areas. Whether these skills are taught through basic or continuing education programs, it goes without saying that the goal of the procedure is to provide the safest possible care by the right caregiver at the right time and the right place as determined by an interprofessional team. As the possibility of including new skills to the midwifery scope has been discussed in many forums over the past five years, many obstetric and pediatric specialists have offered to participate in the education that will be required, as they see that educating midwives in these skills is important for access to safe care in under-serviced settings. As educators we do not see any barriers to providing appropriate learning opportunities. Not all midwives will want to work in a setting that requires them to maintain competency in these areas, but we would suggest all should be introduced to the basics to provide a foundation for those who choose to work in rural and remote areas.

As educators, we are also very comfortable with midwifery student's preparation in regard to the CMO's suggestion that midwives have diagnosis included in their scope. Although a lack of clarity in this area of regulation put midwives in the position of having to call differential diagnosis "assessment", there is no question that differential diagnosis is taught throughout the program, and is a major focus of the problem-based tutorials which accompany clinical placements beginning in the 2nd year of the program. The second year course currently called Midwifery I (after expansion called Normal Childbearing) covers common pregnancy screening, diagnosis and treatment of conditions such as nausea and vomiting of pregnancy; urinary tract infections; vaginal infections; gestational diabetes; breast infections; newborn thrush and breast-feeding problems. Midwifery II (in future Inter-professional Maternity Care Practice) includes extensive coverage of common variations of normal including differential diagnosis and treatment of first trimester bleeding; labour dystocia; prelabour rupture of membranes; postpartum maternal infections; newborns who are slow to gain. The Inter-professional Maternity Care Practice course (formerly Midwifery II) has a particular focus on the roles and scopes of other health professionals and appropriate collaboration, consultation and

referral. The senior year course currently called Midwifery III (Midwifery: Consultation and Complications) covers situations in which midwives may remain primary care givers in situations which require consultation with obstetrics or pediatrics, examples of midwifery differential diagnosis include preterm labour, suspected IUGR and failure to thrive in the newborn. In Midwifery IV (after curriculum change called Midwifery: Maternal and Newborn Pathology), differential diagnosis is taught in layered scenarios about complex cases involving several layers of differential diagnosis as well as interaction with and referral to a broad range of health care providers. Through out these courses students are in full time clinical placements where differential diagnosis is part of day to day midwifery practice and students get extensive experience in decision making and care planning.

Our program includes a mandatory course 2nd year course in Pharmacology which covers not only broad principles related to pharmacokinetics and the particular drugs which midwives can currently prescribe and administer but also common drugs used in obstetric situations, including antibiotics, anti-hypertensives, anti-seizure medications, tocolytic agents. The use of the wide range of drugs used in obstetrics is reviewed and reinforced in the PBL tutorials. The same is true for our mandatory life sciences course in relation to laboratory tests relevant to maternity care.

As educators and academics, our goal is to teach best practice according to the available evidence and national guidelines. We strongly support changes to allow midwives classes of drugs and other changes which will allow a flexible framework that facilitates adaptation as midwives' practices evolve with the incorporation of new evidence and with the development of national midwifery and inter-professional guidelines for best practice. We are aware through our interaction with practices around the province where students are placed, that the current system has created many problems. A very common example is when local physicians and health care institutions expect midwives to independently follow national guidelines such as those developed by the Society of Obstetricians and Gynecologists of Canada for Group B streptococcus prophylaxis and management of postpartum hemorrhage. This is not an unreasonable expectation of a primary care provider. For many midwives and other health care providers it has been hard to understand why the regulatory framework stood in the way of evidence-based practice and extremely frustrating, especially as prompt referral for treatment by other professionals can be problematic. We are aware that in some cases the lack of access to treatment for GBS antibiotics has led some midwives to restrict choice of birth place to women who screen positive, which has meant that many women who choose home birth decide not to screen for GBS colonization. This reflects practice driven by lack of access to recommended treatments rather than a fully informed choice based on access to best practice approaches.

The amendments to the Ambulance Act proposed by the CMO are needed to bring the Act and its regulations back to its intended relationship to midwifery practice which was negotiated as part of the original regulation of midwifery in 1993. It is our understanding that the Act was amended, making it unclear that midwives have the authority to direct

ambulance transport, when safe and appropriate, to a hospital where the midwives have privileges and where obstetrical back-up has been arranged. Midwifery students are taught about interaction and collaboration with EMS professionals, about transfer from out of hospital settings and Level 1 and II hospitals in emergent and non-emergent situations and appropriate reporting to and with interaction with the referral centres.

The CMO proposal extends the role that midwives could play in under-serviced communities allowing health care services to utilize midwives in well woman and well baby care where resources are limited and where the use of midwives skills in these areas. The midwifery education program teaches well woman and well baby care within the first six weeks and involves nurse practitioners, public health professionals, pediatricians and neonatologists in the education of student midwives in these areas. If scope was extended the program could be readily adapted to cover an extended time frame and role, or alternately the competencies could be covered in a continuing education format.

As educators we strongly support the CMO's proposal to allow midwives to participate in hospital credentialing and decision making committees, such as Medical Advisory or Professional Advisory Committees. We believe that a commitment to inter-professional collaboration means that midwives must be included in decision making at all levels of the maternity care system. This is essential to address the restrictions that midwives currently face within their current scope and which act as barriers to midwives making a full contribution to addressing the need for maternity care providers. It is also important to providing effective and efficient care to midwifery clients.

Although I have not commented on all of the changes proposed by the CMO, I hope that I have conveyed the commitment of the Ryerson University Midwifery Education program to working with our consortium partners in providing quality education for the scope of practice for midwifery that will be recommended. We are also happy to work with other partners such as the International Midwives Pre-Registration Program and the Association of Ontario Midwives to establish continuing education for practicing midwives. I know that we have the support of the inter-professional team of educators that works with the Ryerson MEP in responding to the changes in scope that will be recommended.

I would be happy to provide further consultation from the perspective of the Ryerson Midwifery Education Program if that would be helpful.

Response as co-chair of the Ontario Maternity Care Expert Panel

OMCEP met with educators, regulatory and professional bodies, maternity care institutions and individual practitioners. We held focus groups, attended conferences and received correspondence from maternity care practitioners. The midwifery scope of practice was often discussed and we heard many suggestions and rationales for the changes which the CMO has included in its proposal. A great deal of support came from all professions for an expansion of the role and scope of midwives, including from family physicians, obstetricians and from pediatricians. In fact, the only concerns we heard in regard to expanding the midwifery scope came from the medical professional associations, who expressed the view that midwives would be infringing on medical scope. Medical educators and the CPSO supported many of the changes.

Although some bodies such as the OMA and the CCFP expressed concerns to OMCEP that only physicians should be able to prescribe drugs such as antibiotics or order tests such as PIH, OMCEP often heard the opposite from individual practitioners. Many maternity care providers (nurses and physicians) express surprise and confusion at why midwives who are expected to be primary care providers would Rural family physicians were interested in collaboration with midwives and often believed that the sustainability of their local maternity care service in future may depend on a collaborative approach, but they worried that unless midwives could work in a similar scope as family physicians (usual examples were for antibiotic prescriptions and vacuum birth) then a collaborative model would not provide adequate off call time for the family doctors. Obstetric consultants expressed that they expected midwives to do appropriate laboratory test prior to consultation and surprise that midwives would be restricted from doing so. All of the maternity care providers we met with agreed that midwives should be able to independently order GBS prophylaxis and use according to national guidelines, and in fact some expressed anger that midwives were not already doing so as it requires unnecessary consultation which may involve middle of the night calls for what is perceived as routine care.

OMCEP heard from midwives, nurses and physicians working in restricted scope hospitals and in hospitals were midwives were working fully within their scope of practice. One participant who had been involved in several reviews of maternity departments commened that was apparent that a "vicious circle" can develop which affects interprofessional relationships: restricted scope leads to lack of inter-professional respect which leads to restricted scope.

OMCEP's main focus was on how to create a woman and family centred, accessible and sustainable maternity care system. Our interdisciplinary panel supported care providers working as fully as possible given their education and capacities to serve local communities. The CMO's package of changes takes an important step to supporting midwives' contribution to these goals.

Response as a practicing midwife

As a midwife who has worked in remote settings for over ten years, I would like to comment on certain aspects of the CMO changes that are essential to remote practice. I have been privileged to work part-time in the Inuulitsivik midwifery service in Nunavik Quebec, which has provided perinatal care to the women of the east Hudson coast since 1986. The majority of births are attended by Inuit midwives educated at Inuulitsivik. The team also includes southern midwives from across Canada and from other countries, who contribute to the education program and most of whom provide locum support for the local midwives. The success of the Inuulitsivik midwifery service is well documented (supporting documentation has been sent previously at HPRAC's request) and depends on midwives having a broad scope of practice and being prepared to act as lead care providers in maternity care and in emergencies. The births occur in two remote birth centres and in a Level 1 facility with no cesarean section capacity.

Midwives working in remote areas can be in the position of being the most experienced care provider on site and must be able to perform life-saving procedures as per national guidelines when medical help is not available. I have personally been in a position of being the most experienced care provider during weather conditions which would not allow transfer to the referral centre which is over 1500 kms in Montreal. Although in several cases family physicians were present in the health centre, as a midwife I was more familiar with and more prepared to perform a manual removal of the placenta, an umbilical vein catheterization and a repair of a third degree tear than the physicians present. In each of these cases physicians and nurses worked with me in a team, but asked me to take the lead. In the case of the manual removal of the placenta during a blizzard, the physician present simply said to me following the birth "you saved her life". My academic research focuses on this area, and I know from my findings that these experiences are representative of those of other midwives in this setting, which relies on midwives as the lead perinatal care provider. These examples are given to make the point that changes in scope are needed to ensure that in small communities there is the flexibility to have the appropriate care provider provide the best possible care.

Research in northern obstetrics consistently shows that preterm labour and post-partum hemorrhage (PPH) are the most common emergencies and reasons for transfer. Laboratory tests such as fetal fibronectin and treatments such as antenatal corticosteroids and antibiotics are routine in the diagnosis and treatment of pre-term labour. Hemabate, misoprostil and balloon tamponades may be lifesaving in the treatment of PPH. These are examples of laboratory tests, drugs and procedures that it will be important for midwives to be able to use within the context of appropriate protocols for consultation and transfer from remote communities. Much of the routine and extended scope proposed by the CMO supports effective consultation and transfer and should not be interpreted as a substitute for interprofessional team work or midwifery moving into the sphere of

medicine. The proposal supports more effective collaboration with medicine and nursing in accord with national guidelines.

Midwives in rural and remote settings are expected to be flexible and respond to the needs of the community, just as physicians and nurses do. The regulatory framework needs to be responsive to allow the same kind of flexibility in roles that the other professions have. In Nunavik, midwives are often the team members who do PAP and STD clinic, caring for women of all ages and treating partners as required. They do sexual health education and health promotion when local resources require them to play this role. They may also do well baby care, vaccinations and parenting education. A restricted scope of practice does not make sense in communities where the team has to work together to decide who has the best skills and what the priorities for each team member are. When there is a shortage of nurses midwives may take on more, when there is a shortage of midwives the nursing team may step in where scopes and roles overlap.

A broad scope of practice for midwives is essential to returning birth to local communities. Removing northern and aboriginal women from their communities for birth in Canada has created hardship, health risk and inequity for women and families. Aboriginal organizations such as the National Aboriginal Health Organization (NAHO) and the Royal Commission on Aboriginal Peoples have called for the end of the policy of evacuation for birth. The SOGC, the Canadian Association of Midwives (CAM), the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) and the Canadian Association of Nurses (CAN) have all collaborated on the National Birthing Strategy which calls for the return of birth to aboriginal communities and the education of aboriginal midwives. Health Canada, First Nations and Inuit Health Branch is also currently working towards childbirth as close to home as possible and has supported the development of education programs for Aboriginal midwives in Manitoba and Nunavut.

Ontario midwives work in many areas of the province, but have not been as successful as midwives in Quebec, Manitoba, NWT and Nunavut at reaching remote communities. This is in part due to the need for a broader scope and role for midwives in these communities. The changes suggested by the CMO are essential to meeting the goals set by the National Birthing Initiative and meeting the standards of the SOGC for Working with Aboriginal Peoples. A scope of practice for midwifery that does not support aboriginal (and non-aboriginal) midwives to work as fully, effectively and safely as possible in remote communities would be completely out of keeping with principles of equity. Barriers to remote midwifery need to be removed in acknowledgement of the harm that can be done by colonialist attitudes which do not recognize that removing women from communities may be more risky than supporting local midwifery and childbirth.

I will close with some comments based on my experience working at Mount Sinai Hospital which is one of the largest tertiary care centres in the country. Midwives are supported to work fully within their scope, maintaining primary care for epidural analgesia and after consultation for induction and augmentation. Like many other centres

in Ontario where midwives practice fully within their scope, there is support for bringing our ability to practice in line with current guidelines, and again frustration that midwives who are clearly fully knowledgeable and capable of procedures such as GBS prophylaxis or applying a fetal scalp electrode would be restricted from doing so. Obstetricians and pediatricians at Mount Sinai (and at my previous hospital Toronto General Hospital) have generously supported my knowledge and skills to work in an extended scope in Nunavik, offering to mentor me in skills such as vacuum birth, repair of difficult tears, umbilical vein catheterization and intubation to support my work there. This support comes from respect for midwifery and the important role it can play in rural and northern communities. The support is similar to that offered to family physicians working in extended roles doing cesarean sections and anesthesia, for example. This kind of mentoring and support is a model for how to support extended competencies for midwives and family physicians in rural centres.

Finally as a midwife who has worked both pre-regulation and as a registered midwife, part of the debate about updating the scope of midwifery is very familiar to the debate about whether to legally recognize midwifery at all. Arguments about safety and training were the basis of resistance to the integration of midwifery into the health care system. However experience of the past 15 years shows that for the most part midwifery has been accepted and integrated, and that midwives are providing safe and appropriate care to thousands of women and babies in Ontario. Although there are areas where problems with integration remain, there are other areas where the integration of midwifery provides a model of interprofessional collaboration. These settings are without exception, the ones that promote full scope practice for midwives.

There is a long and well documented history both in Canada and internationally of organized medicine expressing concerns about midwifery practice in the name of safety and lack of training. There is also, simultaneously a strong history of collaboration, respect and support among practitioners in the day to day work of providing maternity care. While it is understandable that medical associations seek to protect professional territory, there is no evidence that restricting midwifery scope is in the interest of safety or access to care or that this is a concern for a majority of physicians. In fact, there is a great deal of evidence which supports midwives working in a broad scope providing safe care as respected members of a collaborative inter-professional team. In most countries, midwives attend the majority of births, attending all normal births and many with complications in consultation with obstetric colleagues.

In summary:

Working as a respected member of the health care team builds mutual understanding and trust. Working fully within your scope and being supported to use your skills to serve women and babies in the community you work in is rewarding and helps keep caregivers in their professions. Midwives, like other primary care health care providers, need a scope of practice which is defined in such a way that they can respond to changes in evidence, the development of new drugs and technologies and collaborate effectively

with other health care providers. Midwives are educated to be able to apply evidence to practice and make clinical decisions within their scope of practice, to know their limitations and to consult and refer appropriately. Midwives share the same goals of safe care as close to home as possible as are expressed in many reports from national and provincial bodies reviewing maternity care. The CMO proposal provides the flexibility for midwives to respond to community need, changing evidence and national standards.

Thank-you for this opportunity to respond and please feel free to contact me at Ryerson if any further consultation would be helpful.

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