

Submission to HPRAC
Regarding the Consultation Discussion Guide on
Issues Related to the Ministerial Referral on
Interprofessional Collaboration
Among Health Colleges and Professionals



ASSOCIATION OF ONTARIO MIDWIVES

*Represents Registered Midwives and
Promotes the Profession of Midwifery in Ontario*

Introduction

The Association of Ontario Midwives (AOM) welcomes the opportunity to comment on the consultation guide regarding issues related to the Ministerial referral on interprofessional collaboration among health colleges and professionals. We have grouped our key points below according to the major themes identified in the consultation guide.

Defining Interprofessional Collaboration

“Mutual respect and shared knowledge” as criteria of IPC imply an absence of hierarchy amongst providers. This should be explicitly spelled out, as it makes clear that there can be shared care where the “most responsible provider” can change depending on which competency is demanded and that there is no one member of the team or one profession who is necessarily always in charge.

We strongly support enhanced scope of practice for midwives as participants in IPC. However, such practice must be enabled rather than imposed as some consumers and some communities may not need midwives to work to their broadest possible scope. Yet in some communities, enhanced scope is a critical component that will enable midwives to work collaboratively with other maternity care providers to best respond to the varying needs of women in diverse communities, including in rural and remote settings. Enhanced scope for midwives will provide increased flexibility to the province in developing and sustaining a maternity care system that ensures women have access to high quality care in the communities where they live.

Eliminating the Barriers to Collaboration Among the Colleges

The AOM strongly believes that health care professions should be self-regulated by independent, profession-specific Colleges. Self-regulation of health care providers is not an obstacle to IPC. In our view, the client protection advantages of self-regulation, including the benefit of peer review and oversight, are vitally important to protect. The road to effective and efficient IPC is through the strengths and opportunities available within professional self-regulation.

We do not believe that the RHPA represents a barrier to collaboration at the college level.

The *perception* of increased liability by physicians in relation to midwives, versus liability issues *per se*, is a major problem for interprofessional care. Midwives often have to consult unnecessarily with doctors (because of hospital restrictions on their scope of practice, and problems with the drug regulations), and thus doctors perceive that they have more liability when working with midwives. Joint statements by insurance companies, such as CMPA-HIROC Joint Statement on Liability Protection for Midwives and Physicians can help to alleviate such concerns. The determination of minimum expected terms and conditions for insurance coverage should be those that would satisfy the needs of injured parties to seek appropriate remedies under our existing laws. This should be left within the purview of the Colleges to determine on a yearly basis.

Developing Enablers for Collaboration Among the Colleges

1. *Common standards and professional practice guidelines*

Professional practice guidelines have typically been developed by professional associations, not colleges. This should continue to be the case as we move forward with IPC initiatives.

The assumption in the Guide seems to be that common standards of practice and professional practice guidelines are necessary and desirable. This is not necessarily the case. It may be possible to develop interprofessional models of care where each professional applies their own standards and guidelines when they are the most responsible provider in a case. In fact, in a maternity care scenario, it is both necessary and possible to have different professionals knowingly and effectively following the professional practice guidelines of their own professions even though they may differ from the guidelines used by another provider in an interprofessional team. The goal is to allow providers with different scopes of practice, philosophies and core competencies to work together in a collaborative way, each according to the standards of their profession. It may well be possible and, in fact, desirable for IPC teams to have *protocols* that have been agreed upon by all members of the team.

If there were a need for common professional practice guidelines, these would have to encompass different ways of practicing and not give weight to one set of guidelines at the expense of another, setting up a hierarchical situation, or reducing standards to the common denominator. For example, under midwives' regulations, they must offer the choice of a home or hospital birth to their client. But doctors' standards and guidelines do not generally accommodate home births. Hence in an IPC situation, a midwifery client must not be in the position

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where she is not given choice of birthplace. Choice of birthplace is after all a central tenet of the midwifery model of care.

2. Ministry-directed Initiatives

Underlying funding barriers to IPC must be dealt with, prior to or parallel to Ministry initiatives to foster collaboration amongst the Colleges, in order for IPC maternity care projects to materialize. Midwives, doctors and other professionals on the ground are interested in and motivated to engage in interprofessional care initiatives, where they see a need in their community. For example, midwives and other health care professionals in Alliston and Thunder Bay have tried to develop interprofessional pilot projects, creating a team of obstetrical care providers, in coordination with the College of Midwives. These projects failed or were seriously limited not because of the Colleges, but because of the differing ways in which midwives, nurses, and doctors are compensated.

3. Legal Enforceability of Standards of Practice and Professional Practice Guidelines

The development of professional practice guidelines must rest with professional associations. Professional practice guidelines are contextual and require clinical judgement regarding their implementation. This is not an appropriate function for a College. The role of the College must be to create regulations that keep pace with clinical practice. Colleges must be enabled to stay current to ensure public safety. Currently, changes to regulations developed by Colleges have to go through a Ministerial approval process that is severely time consuming—often taking years to implement changes needed to keep pace with changes in clinical practice. This cumbersome approval process does not permit Colleges to respond to changes in practice in a timely way. This point is well illustrated in

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midwifery, where the list of drugs that midwives are able to access is dangerously out of date and restrictive. Colleges must be enabled to create regulations that do not require Ministerial approval. Following the example of drugs provided above, if Colleges were enabled to regulate practice from approved drug categories, they would be able to respond quickly to changes in clinical practice as well as drug availability. Ensuring regulation is responsive to current clinical practice is not only critical in ensuring public safety, but also critical in fostering successful interprofessional collaboration. Again, working with the example of drugs, it enables providers to refer only when medically necessary, as opposed to being forced to refer simply because College regulations are not in keeping with current clinical practice.

IPC at the Clinical Level

A *very general* legislative requirement to work and communicate effectively in or between teams could be useful but simply requiring collaboration will not achieve interprofessional care. In order for interprofessional care to succeed, providers must be enabled to work to their broadest possible scope and other barriers, which are perhaps outside the scope of this consultation but highly relevant, such as cultural differences among professions and funding barriers, must be also be addressed.

Legislation and Policy Barriers to IPC

Changes to legislation, regulation, and policies can have a profound effect on interprofessional collaboration at the clinical level, as they create a common set of parameters within which expectations and practices can be developed. In terms of legislation and policy, there are a number of barriers to effective interprofessional collaboration that are of concern to midwives:

1. *The Midwifery Act*

Scope expansion is a critical enabler of IPC initiatives in maternity care.

However, the *Midwifery Act* for example, unnecessarily limits midwives' scope and has the potential to hamper IPC. Specifically:

- The term “diagnosis” is missing in the description of scope of practice in *The Midwifery Act*. Enabling midwives to diagnose in turn enables them to prescribe and to respond to client needs in an appropriate and timely way as primary care providers. Midwives must be able to diagnose in order to function fully in interprofessional teams and to respond appropriately to the needs of clients. Without the ability to diagnose, a midwife must refer to a physician when a client needs access to drugs for a condition which is within her scope to diagnose and treat. These kinds of unnecessary referrals harm collaborative relationships, are costly to the health care system, and inconvenient to clients.
- Midwives are limited to prescribing from drug lists. Drug lists do not allow for timely responses to changes in drugs in a manner consistent with patient safety and health care effectiveness and efficiency. The current system engenders delays, duplication of work, undermines physician respect for midwives, and jeopardizes patient safety. We were pleased to see the potential for midwives to prescribe from drug categories in Bill 171. Enabling midwives to prescribe from drug categories will strengthen interprofessional collaboration.

2. *The Public Hospitals Act*

In general, the *Public Hospitals Act* entrenches the hierarchy of physicians over other health care professionals in the hospitals, and thus is antithetical to interprofessional care and its spirit of collaboration and mutual respect.

- The *PHA* does not provide for the same rights of due process for midwives in applying for privileges as is present for physicians. Physicians must receive a response within 60 days of application for privileges, and have an appeal process if they are denied. Midwives do not have such rights and privileging is a consistent problem limiting the growth of the profession and undermining collegiality. Midwives need to have the same rights to due process in order to facilitate IPC.
- In the *PHA*, Regulation 965, midwives are not included in the voting membership on Medical Advisory Committees and thereby credentialing committees (which are often subcommittees of the MACs). Physicians thereby determine the fate of midwives' applications for privileges, which sets up a hierarchical structure that is detrimental to mutual respect. Midwives must have voting membership on credentialing committees, to have a true system of peer review and to facilitate collaborative IPC.

3. *Differential Payment Models*

The Ontario midwifery model provides high quality care that is enhanced by course of care funding. Course of care funding models facilitate significantly more time spent by midwives in direct client care, which in turn enables the achievement of high quality outcomes. Course of care funding mechanisms avoid the incentives that are often linked to fee-for-service funding models that reimburse providers for performing specific services. In spite of the efficacy of the

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midwifery model of funding, obstacles exist that prevent midwives from working in IPC models. While midwives are not interested in being funded on a fee-for-service basis, members of our profession are interested in pursuing other models, or combinations of models, that would enable midwives to be part of an IPC model. Possibilities include salary, partial salary, or sessional funding, each of which could potentially fit with a partial course of care model. We are optimistic that the growing number of physicians who are choosing alternative payment plan (APP) funding will provide more opportunities and options for IPC.

We envision that associations and colleges will be involved in identifying suitable communities, model structures and funding models for IPC projects. In the past, funding barriers have led to the demise or severe limitation of various IPC pilot projects in maternity care in Ontario. This issue must be resolved before College attempts to enable and support interprofessional models can succeed.

4. The Power of Hospitals

Hospitals' power to decide whether midwives can practice to their broadest possible scope means that midwives must often transfer care for activities such as augmentation and epidural monitoring, when these activities are currently already within their scope. Midwives must be enabled, by regulation of the *Public Hospitals Act*, by Ministry planning, or by LHIN direction to hospitals, to practice to their broadest scope possible. As well, hospitals currently decide, based on their resources, whether the number of births or the number of midwives will be capped, regardless of the demand for midwifery or the need for maternity care providers in the area. There is a strong role for the Ministry of Health and for the LHINs in planning and enforcing a more rational health human resource policy that ensures that funding is allocated in a manner sufficient to meet the needs of women to have access to the most appropriate care provider as close to home as possible.

5. The Policy of Differential Consultation Fees

Fees for midwife-requested assessments are commonly less than those for physician-requested assessments, which undermines collaboration with maternity care specialists. The fees for consultations need to be harmonized, so that midwives can refer directly to specialists, and so that there will be less reluctance by specialists to consult with midwives.

6. The Ministry Published Paramedics Standards Document, "Basic Life Support Standards"

This document needs revision to clarify that, when the standards of the paramedic conflict with the College standards of the midwife, the midwife remains the most responsible provider. Lack of clarity on this issue has led to dangerous situations for women, and undermines collaboration amongst these providers.

Conclusions

The AOM supports the initiative of the government to determine ways of effectively developing and implementing IPC. Colleges are important players in this arena. However, there is a need to go beyond Colleges to look at larger legislative changes, pilot projects, and funding changes, in order to facilitate IPC. As well, associations, with their direct contact with members and their roles in professional practice guideline development, continuing education programs, and member education and mobilization, have an important role to play in fostering IPC.

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