

As a registered midwife who has been practicing for nearly 12 years in a community in which I am privileged to work in an incredibly collaborative, supportive and respectful interprofessional setting in one hospital where I hold privileges and yet am challenged to work in a second hospital in which interprofessional relationships across the board (not just with midwives) suffer from a less than ideal interprofessional structure, I can clearly state that a spirit of collaborative mutual respect and appreciation is critical not only to the provision of high quality patient centred care but that it is also essential to appropriate resource management. Patients seeking maternal and newborn care who have the flexibility to make choices about where they will have their babies can and will choose to receive care outside of their communities where those communities don't provide a supportive, respectful environment and where outcomes can be affected by the lack of collaboration on the part of caregivers. In addition lack of resources in communities where care should remain local for the women and families within them suffer due to demands that outstrip supplies and resources and this can have a negative impact on interprofessional relationships even in the best of circumstances. I want to say as well that while I believe strongly in a collaborative and mutually respectful model of care that recognizes the talents and skills of all participants both from a regulatory perspective and in terms of resource allocation and compensation, I don't necessarily believe that means the care has to be offered in a fully integrated way in order to ensure that care is of the highest quality, is patient centred and that resources are allocated in a rationalized way. I believe in order to offer patient centred care, we have to continue to offer a variety of models that can meet the needs of the variety of patients who require maternity care.

I fully support the realization of the scope of midwifery to a) allow all midwives across the Province to practice fully within their scope should they wish to do so and should the demands within their communities warrant it and b) I also support the expansion of the scope of practice beyond its current iteration again for the above mentioned reasons. I fully support the integration of midwifery into the health care system through the implementation of Departments of Midwifery with seats on Medical Advisory Committees. In addition I would strongly support the development of processes to ensure that changes to scope of practice that are evidence based and per community standard be allowed to occur on a more efficient system than is currently in place in order to ensure that Midwifery practice is able to remain current and relevant and to limit liability concerns related to outdated practice restrictions.

Midwives who are forced to work in conditions in which neither their scope nor their rightful place as a member of the health care team are honored, face a perceived general lack of understanding, trust and respect for their abilities, skills, experience and training. The unusually high rate of transfer of care away from Midwives in some communities that is required by restrictive hospital rules and regulations (rather than CMO guidelines), combines with the confusion around how to manage care in those cases to make it a difficult for Nursing and Medical staff to feel comfortable and confident in a Midwife's ability to manage care competently. With the high rate of transfer of care, there is minimal opportunity for Nursing and Medical staff to actually observe Midwives exercising their skill and experience.

The placement of the division of Midwifery within departments of Family Practice or Obstetrics and Gynecology has had the unfortunate result of limiting the integration of Midwifery within some hospitals. The lack of formal structure and function for Midwifery within institutions has led not only to a lack of a clear accountability structure for Midwives but also to a lack of voice for Midwifery. Midwives are left with a lack of ability as a profession to have their issues and concerns heard and attended to. The absence of a formal place for midwifery within these institutions leads to a lack of clarity about how Midwives address issues related specifically to their profession and leaves them severely limited. Education opportunities, midwife orientation, midwifery skill certification and reviews for midwifery cases with significant outcomes which in other departments would be seen as "hospital activities" can end up being left to midwives to manage on their own initiative with no one able to identify who or where the responsibility lies to ensure those activities take place and as such, whether or not they occur can be on a very ad hoc basis. Every decision currently being made, that affects either Midwifery directly or perinatal care in general, can therefore occur largely with the absence of any midwifery input within organizations where Midwifery is privileged within another department. The appointment of a head of the division of Midwifery comes without any clear structure for the role, compensation, expectations, selection process or term of service. The lack of formality afforded the position limits the head Midwife's ability to be effective and therefore limits the ability of Midwifery to be integrated, represented and to function as a member of the team. Midwifery is a self regulating primary care profession governed by the restrictions of the Regulated Health Professions Act and as such should be afforded a position within the structure of the organization with a self governing department that like all other departments within the institution would have accountability, responsibility and voting privileges at the Medical Advisory Committee.

The lack of formalized process for orientation, communication and assembly across disciplines can also lead to a lack of knowledge and understanding on the part of Nursing and Medical staff about the education, training, skills and experience of the Midwives. Additionally there can still be much confusion about the scope, role and responsibility of the Midwife as a member of the health care team. All parties involved would benefit from a formalized orientation process to familiarize staff with the Midwives and to familiarize Midwives with the staff and hospital procedures. A formalized in-service, lunch and learn or meeting structure that allowed Nursing and Medical staff to become educated about the Midwifery scope of practice would also be beneficial and could be undertaken by Midwives who hold privileges at the hospitals, by Midwives working at another facility in which more clarity exists for Midwives or by representatives from the Association of Ontario Midwives or the College of Midwives of Ontario. In addition, formalizing such a process would compel Midwives who may have drifted to the periphery (whether by design or default) to take a more active and centralized role in team function.

For those Midwives who are able to offer their clients a choice of birthplace where care is not transferred for non CMO indications preferential selection of those hospitals will likely continue. Women who have chosen to be attended by a Midwife will generally continue to want to have their Midwife play the fullest possible role in their care and will opt to deliver at a facility where this is most likely to occur. This will continue to make it challenging for Midwives to

generate the necessary volume of births within restrictive hospitals to make fellow staff members comfortable with their roles, responsibilities and scope of practice. The more time Midwives spend working with staff the more effective the communication will become and the more familiar and comfortable all parties involved will become.

I think that one of the areas in which we have an opportunity to contribute to the removal of barriers to practice is in our registration status. I believe that with our current requirement that active practice (the ongoing provision of a certain volume of clinical care) is necessary to maintain registration as a midwife we are potentially compromising the ability of midwives to continue to contribute in a meaningful way to the profession if they are unable to maintain their active practice status and as a result over time lose their ability to use the title of registered midwife. The two particular groups that I see affected on a regular basis are midwives who at the end of their careers, retire and/or decrease caseload to the point that they are unable to maintain registration and midwives who due to the burdens/challenges of young families are challenged to work fully within the model of care and as a result potentially end up leaving the profession altogether rather than practicing in an alternate or limited capacity for a few years. It seems to me that both of these groups have a lot (especially the retired midwives) to contribute to the profession, maternal/newborn care and interprofessional collaborative practice whether it is in a modified clinical capacity or in an administrative role. If we truly want to develop a more integrated and/or interprofessional capacity it is imperative that midwives also start to be able to take on non clinical roles within community and institutional settings and the fact that once your active practice status is expired you can't call yourself a midwife anymore is a significant barrier to being able to apply for roles like Maternal Newborn Health systems managers or any other such positions that may exist for midwives outside of the scope of midwifery specific stakeholder groups. Within the midwifery stakeholder groups, retired or on leave midwives may be well enough known to be considered for non clinical roles or roles in which their clinical expertise may be appreciated even if they aren't actively practicing... But outside of the midwifery milieu, once you are no longer a registered midwife it becomes a challenge to be considered for the role of postpartum clinic manager or birthing suite manager or clinical resource leader or any other such position that would rightfully allow midwives to contribute to the broader maternal newborn health care arena and ensure that we are truly making an interprofessional. If midwives are to be truly members of the interprofessional team then they must contribute in all aspects of the health care system and its framework and not simply as clinicians.

I would strongly encourage the development of a registration category that allows members to retain their title even when they are not actively practicing so that they can retain the ability to go out into the world beyond midwifery clinical practice in order to ensure that midwives are able to integrate into all aspects of the health care system and structure in a meaningful way.

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