

Collaborating to provide safe, quality care for mothers and their newborns



**Submission from the Ontario College of Family Physicians
(OCFP)**

to

**The Health Professions Regulatory Advisory Council
(HPRAC)**

In Respect to

The College of Midwives of Ontario Scope of Practice Review

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Introduction

The Ontario College of Family Physicians (OCFP) wishes to thank the Health Professions Regulatory Advisory Council (HPRAC) for this opportunity to respond to the College of Midwives of Ontario submission respecting the Review of the Scope of Practice of Midwives. The OCFP appreciates the government's interest in enhancing interprofessional collaborative care (IPC). At the outset, we would like to express our interest in, and support for IPC and for midwives as key members of interprofessional teams. The OCFP is interested in continuing this dialogue to ensure IPC among midwives, family physicians, obstetricians, gynecologists, nurses and other health care providers and to address the expanding and changing scope of practice.

The Ontario College of Family Physicians (OCFP) is the Ontario Chapter of the College of Family Physicians of Canada (CFPC). The OCFP is a provincial, voluntary, not-for-profit organization whose mandate includes undergraduate, post-graduate education, the continuing professional development of family physicians and the maintenance of high standards of medical care and education in family practice. We are the voice of family medicine in Ontario and represent more than 8,236 family physicians who provide patient care for remote, rural, suburban, urban and inner city communities throughout Ontario; many of whom deliver maternal and child care. The building and maintenance of high standards of practice, the continuing professional development of our members and improved access to high quality family medicine services for all residents of Ontario are at the heart of our organization. The College strives to improve the health of Ontarians by promoting high standards of medical education and care in family practice, by contributing to public understanding of healthy living, by supporting ready access to family physician services, and by encouraging research and disseminating knowledge about family medicine.

The OCFP was awarded a Primary Health Care Transition Fund grant to study the potential human resource crisis in obstetrical care. The participants in our study included obstetrical nurses, midwives, family doctors and obstetricians, as well as learners amongst all four disciplines. Our study made several recommendations anchored in that premised that collaborative practices amongst the providers. Key to the model was regulatory changes to support midwives to work in collaboration. It is disappointing to see that the College of Midwives is not requesting changes to make it easier for them to work with other providers, indeed, the requests for further increases in the scope of practice seem to be aimed at further distancing midwifery from their professional

colleagues. Many of the requests currently are handled, and handled well, through delegation and through consults with physicians adding a layer of safety for mother and child that should not be removed. While wanting to support midwives in their quest to increase their scope of practice, our recommendations are based on the need to ensure the safety of mother and newborn, first and foremost. We also recognize that midwives working in underserved areas of the province may require additional skills; however, further education and physician back-up remains the preferred options rather than an opened ended increase in scope of practice for all midwives.

Overall Perspective on Interprofessional Collaboration (IPC)

Interprofessional Collaboration (IPC) is built upon the bedrock of mutual trust and respect. It can be enabled; it cannot be legislated. As in other submissions to HPRAC, the OCFP is emphasizing that the most significant enablers to IPC include system and practice supports that exist outside of measures to change legislation or to expand scopes of practice. Key enablers including compensation and funding; interprofessional education and training that supports collaborative practice; quality improvement programs; interprofessional communication policies, protocols, guidelines; team building and skill development; flexible organizational structures; patient/caregiver involvement; health human resource planning; and, integrated health records, are key to moving IPC forward and overcoming a long history of silos of professional education and practice. The OCFP believes that it would be more effective if these key enablers were developed to support midwives working together in teams with family physicians, specialists and interdisciplinary health professionals. Moreover, it's our experience that focusing on enhancing scope of practice, particularly without attention to these enablers, can actually foster independence, rather than interdependence and collaboration and therefore contribute to silos. Changes in systems of care and organizational practices would enhance collaboration much more productively than legislative changes or scope of practice expansion.

The OCFP's Response to the CMO's Proposed Scope of Practice Changes

While the OCFP is grateful for the opportunity to respond to this submission, we must express our concerns about the short timeframe allocated for this response, which precluded the opportunity for extensive consultation. Notwithstanding this limitation, the OCFP's submission reflects our membership's position on IPC, which includes extensive consultation from previous submissions to HPRAC's process and it specifically includes the views of several family physicians with extensive experience working in partnership with midwives, who hold academic teaching positions with different departments of family medicine, are directors for Family Medicine Residency Programs and are involved in research in the field of primary care obstetrics.

The OCFP's comments in regards to the specific scope of practice revision requests are noted in the table on the following pages, but we would like to highlight four general concerns at the outset:

1. Education and Training: The College of Midwives of Ontario's request does not indicate that there will be additional education and training to support the enhanced or expanded scope of practice requests. It is the OCFP's position that presently, midwifery education, training and continuing professional development are not comprehensive enough in breadth or depth, to support the far-reaching requests being proposed. This is a recurring theme in our response to the specific scope of practice change requests, as noted in the table following this section. Ensuring appropriate and adequate training is a fundamental first step before scope of practice enhancements or expansions can be considered. Ensuring educational programs that foster the development of competence and confidence of all learners was a key finding in the Babies Can't Wait research project.¹
2. Extension of practice into well women and newborn/well baby care and fragmentation of primary care: It is the OCFP's position that this extension requires a knowledge and understanding of comprehensive primary care that is clearly outside of the scope of the midwives' training. Further, this would contribute to fragmentation of care, which we know is counterproductive to positive health outcomes. Extra training to permit specified activities (Pap smears, contraceptive counseling etc) in underserved areas might be acceptable, but the main

¹ Babies Can't Wait: Obstetrics Care in Crisis. Final Report to the Primary Health Care Transition Fund. August 31, 2006; Ideas into Action. Babies Can't Wait Maternity Care solutions for Ontario A Consensus Building workshop. May 2006.

message is that primary care services should not be fragmented in this way; well-women and well-baby care is central to family medicine.

3. Interprofessional Collaboration and Education: The OCFP does not view this request for the proposed scope of practice changes as one that supports interprofessional collaboration (IPC) but rather, is a request to increase the Midwives Scope of Practice in a silo manner. Specific changes to the Midwifery Act should be informed/guided by the findings from the *Babies Can't Wait: Obstetrics Care in Crisis* (2006) research. This was a collaborative project that involved many partners, including the Association of Midwives of Ontario.² A key theme from this work was the need to address shared philosophy through training, education and promoting interdisciplinary, shared-care, collaborative practice. A few ideas towards this end includes easy access to inter-professional curricula at the undergraduate and postgraduate levels and interprofessional continuing education and training opportunities, mentorship programs, role modeling, refresher courses and cross training. Moreover, “maternity care professionals should be supported by their professional associations and educational faculties to work together to promote and maintain a culture of quality care, cooperation and collaboration that celebrate the joys of childbirth and the positive outcomes of teamwork in each community and in each hospital providing maternity care.”³ Team building and skill development should be a core policy/ program area that Colleges address collaboratively, given their continuing professional development mandate and concern for improved skills and competencies of members. It is the OCFP’s position that the requested scope changes should be further explored within the context of interprofessional education, training, collaborative practice and guidelines. It’s the family physician or specialist that is called when problems arise, yet it’s the experience of some physicians that midwives resist their help and are unwilling to recognize the limitations of their scope when problems arise and do not accept support with deliveries. We are concerned that the focus on scope of practice is and will remain divisive, while supporting health care professionals to learn and work together in the best interest of patients, health professionals and the system, is a more appropriate focus.

4. Physician substitution: While the OCFP supports the concepts that all regulated health professionals work to their maximum competence and capability, that they optimize their skills

² Ibid.

³ Ideas into Action. Babies Can't Wait Maternity Care solutions for Ontario A Consensus Building workshop. May 2006

to ensure access to high quality care and that health professionals be regulated in a manner that maximizes collective resources and supports personal and professional interests, the scope of practice requests by the College of Midwives of Ontario appears to position midwives as physician substitutes and without due recognition for the extensive and comprehensive training that family physicians receive. The focus must be on collaboration, rather than competition with, or replacement of, family physicians. While the various regulated health professionals have specialized/narrower scopes of practice, it must be acknowledged that family physicians have the broadest scope of practice, which often places them in a clinical leadership role. However, this does not imply a direct supervisory role over all of the clinical services provided by a team. The ultimate focus should be on interprofessional teams, actively working together in the joint care of the patient, producing synergistic results, with team functioning that is anchored in the principles of collaboration, cooperation, open communication and mutual respect and trust. Moreover, using the shortage of family doctors cannot be an argument that is used to support expanding scope of practice; this is a band-aid solution. Working in an interprofessional model of care should be the goal. Supporting the various disciplines to work towards their full scope of practice or towards an increased scope of practice is a minor secondary goal. Safety and quality of patient care should always be our first consideration. That goal is best met in a model of interdependent care that builds on the knowledge and skills of the family doctor and the trusting relationship established between the doctor and his or her patients. Interdependence, rather than independence should be the guiding framework for IPC both at the level of the Colleges and practice level.

In addition to these general areas of concern, we are listing specific areas of concern, which correspond with the items under review (e.g. the Midwifery Act, the Regulations under Midwifery Act and Other Legislation). These areas of concern are outlined in the table on the following pages.

Midwifery Act

| Midwifery Act | | | | RESPONSE FROM THE ONTARIO COLLEGE OF FAMILY PHYSICIANS (OCFP) |
|---|---|---------------------|---|--|
| Current Legislation | Proposed Changes to Legislation | Type of Scope | Rationale | |
| “Scope of practice statement: The practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries” | Revise to allow well-women/well baby (> 6 weeks) care | Extended practice | The current legislation limits midwives involvement in: Primary maternity care, interprofessional collaboration and care in underserviced areas | The OCFP does not understand the rationale for this request. It would be rare to find a community that has midwives only. This request would see midwives as substitutes for family doctors and their nursing colleagues. The provision of care for the mother and child should be handed over to the doctor or nurse sooner rather than later. This request requires additional training, education and skill development and therefore, changes to the Midwifery program and/or enhanced interprofessional education and training before this could ever be considered. At a minimum, there should be a list of diseases identified where midwives would be trained to highlight their competence. |
| | Revise to allow pre-conception counseling | Routine practice | The proposed amendments would bring Ontario’s midwives in line with the national standards of midwifery care | This requires clarification of scope along a continuum of potential areas. Is the College proposing lifestyle/nutrition counseling or genetics counseling? This request also signals the need for additional education and training. |
| | Remove “spontaneous” to increase flexibility of scope – e.g. for conducting artificial rupture of membranes for induction | Routine practice | | |
| Clarification of Activities within Current Authorized Acts | | | | |
| Putting an instrument, hand or finger beyond the labia majora during pregnancy and the post - partum period | Clarify to allow emergency manual removal of placenta | Routine - emergency | Recommendations from OMCEP report. In line with national midwifery standard. Support midwives’ involvement in: | This should not be routine; it is considered by physicians to be very risky. Possibly in an emergency and in underserviced areas with the guidance of a consulting physician, however, there may be the need for a category of midwives in these areas with advanced skills. Once again, this request requires additional education and training. Family physicians receive special training in this area. At the very least, this is an area for collaborative practice where midwives with additional training are still required to seek consultation with a physician. |
| | Clarify to allow | Extended practice | primary maternity | |

| Midwifery Act | | | | RESPONSE FROM THE ONTARIO COLLEGE OF FAMILY PHYSICIANS (OCFP) |
|--|--|-------------------|--|--|
| Current Legislation | Proposed Changes to Legislation | Type of Scope | Rationale | |
| | vacuum extraction | | care; interprofessional collaboration and care in underserved areas | for collaborative practice where midwives with additional training are still required to seek consultation with a physician. Complications often arise and midwives should work in collaboration with physicians. |
| “Performing episiotomies and amniotomies and repairing episiotomies and lacerations not involving the anus, anal sphincter, rectum, urethra and periurethral area” | Clarify to allow 3 rd and 4 th degree tear repair | Extended practice | | This should not be permitted unless under delegation in a rural/remote area. This procedure requires extensive training and is something family physicians often refer to obstetricians. Again, it must be emphasized that the category of midwives working in this environment should have additional education and training. |
| Extension of Current Authorized Acts | | | | |
| Performing a procedure on the tissue below the dermis” “Taking blood samples from newborns by skin pricking or from women from veins or by skin pricking” | Scalp clip: beyond dermis | Routine practice | Recommendation from OMCEP report. In line with national midwifery standard | This request is reasonable and should be permitted to achieve effective fetal monitoring. However, when this procedure is required, it could be an indication that higher level care is required and immediate referral to a physician is required. |
| | Scalp Ph: beyond dermis | Extended practice | | This should not be permitted; it is well outside the midwives’ scope and in fact is considered a very high risk procedure for physicians. |
| | Taking blood from fathers / donors: beyond dermis | Routine practice | Support midwives’ involvement in: primary maternity care, | This request requires clarification about the purpose for the blood collections. |
| | Revise to allow umbilical vein catheterization on newborns | Routine practice | interprofessional collaboration and care in underserved areas | This should not be permitted. What are other indications (e.g. resuscitation drugs) |
| Managing labour and conducting spontaneous vaginal deliveries | Remove “spontaneous” to increase flexibility of scope (for example, conducting | Routine practice | | The purpose needs clarification because it raises many safety concerns. |

| Midwifery Act | | | | RESPONSE FROM THE ONTARIO COLLEGE OF FAMILY PHYSICIANS (OCFP) |
|---|---|-------------------|--|---|
| Current Legislation | Proposed Changes to Legislation | Type of Scope | Rationale | |
| | artificial rupture of membranes for induction) | | | |
| | Revise to allow c-section assist | Extended practice | | This requires further interprofessional discussion; it may be considered with appropriate training. |
| Addition of Controlled Acts | | | | |
| Putting an instrument, hand or finger beyond the larynx | Intubation: beyond larynx | Routine practice | <p>Neonatal Resuscitation Program Standard.</p> <p>Inline with national midwifery standards.</p> <p>Recommendation from OMCEP Report.</p> <p>Support midwives' involvement in: primary maternity care, interprofessional collaboration and care in underserved areas</p> | We assume this is aimed at newborn resuscitation. It is a very difficult skill to acquire and even more difficult to maintain skills. Midwives should be functioning in low risk situations with resuscitation rarely needed. Other methods of airway management can be used until skilled assistance is available. Physicians and paramedics receive special training and require ATLS/ACLS recertification on a routine basis even in high volume practices.. |
| Communicating to the individual or his or her personal representative a diagnosis identifying a | Communicating to a patient or to his or her representative a diagnosis made by the member | Routine practice | <p>In line with national midwifery standards</p> <p>Allow discussion of results of tests –</p> | Formulating and communicating diagnoses and helping the patient to understand the next steps in the assessment, diagnosis and treatment plan requires broad-based medical training and continuing professional education. At the very least, this should be part of the collaborative team approach. |

| Midwifery Act | | | | RESPONSE FROM THE ONTARIO COLLEGE OF FAMILY PHYSICIANS (OCFP) |
|--|--|------------------|---|---|
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| disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis | identifying, as the cause of the patient's symptoms, a disease or disorder that can be identified from the results of any laboratory tests or other tests and investigations that the member is authorized to order or perform | | increases efficiency and effectiveness of the maternity care system Reduces unnecessary utilization of physician services, allowing physicians to use skills appropriately | |
| Putting an instrument, hand or finger beyond the anal verge | To conduct routine perineal repair procedure | Routine practice | Support midwives' involvement in: primary maternity care, interprofessional collaboration and care in underserviced areas | This procedure is rarely needed. |
| | For the administration of suppository medications | Routine practice | | This request requires clarification. |

Regulations under Midwifery Act

| Regulations under Midwifery Act | | | RESPONSE FROM THE ONTARIO COLLEGE OF FAMILY PHYSICIANS (OCFP) |
|---|---|-------------------|---|
| Action | Proposed Changes | Type of Scope | |
| Designated Drugs Regulation O.Reg.884/93 The current amendment request before the Ministry includes, but is not limited to the following drugs (the complete submission is attached in Appendix F) | Add antibiotics for the treatment of GBS | Routine practice | All of these requests could potentially be explored, but raises concerns about the overall level of education and training required to recognize potentially harmful situations that require antibiotics. These areas would benefit from collaborative practice where midwives with additional training are still required to seek consultation with a physician. |
| | Add antibiotics for the treatment of mastitis | Routine practice | |
| | Add antibiotics for the treatment of Bacterial Vaginosis | Routine practice | |
| | Add antibiotics for the treatment of Urinary Tract Infections | Routine practice | |
| | Add MMR vaccine | Routine practice | This request should not be permitted and is well beyond the midwives scope of expertise and raises issues around anaphylaxis and informed consent, not to mention continuity of care issues. |
| | Add Varicella immunoglobulin | Routine practice | This request could potentially be explored but still raises concerns about whether this should be given to pregnant women. |
| Additional changes under consideration | | | |
| The following are proposed as additional amendments to the Designated Drugs regulation | Childhood vaccinations | Extended practice | This request should not be permitted without extensive training and education in child development, physiology, pediatrics etc. This is clearly moving into an area in which midwives are not trained and educated. |
| | Antibiotics for Sexually Transmitted Infections | Routine practice | This request should not be permitted and is problematic because it's moving into more complicated areas such as the multiplicity and complexity of STDs, what are the antibiotics of choice, what are the interactions among antibiotics with other drugs; what are the interactions of antibiotics with the mother and child. |

Other Legislation

| Other Legislation | | | RESPONSE FROM THE ONTARIO COLLEGE OF FAMILY PHYSICIANS (OCFP) |
|--|--|---------------------|--|
| Action | Proposed Changes | Type of Scope | |
| Laboratory and Specimen collection Centre Licensing Act | Add cord blood gasses test | Routine practice | Suggests a major problem with the newborn that should be under the care of a physician. The taking of cord gases is appropriate but a family doctor must be called. |
| | Add drug screen | Routine practice | This request is unclear and raises the question of who is directing the midwives to do the drug screen? Is this initiative based on their own judgment or is it based on collaboration with a physicians or other health professional? |
| | Add PIH | Routine practice | This request should not be permitted and raises very serious concerns because PHI is a high morbidity and mortality condition: if it's a request to screen, the fact that there is a concern means a) that diagnosis to screen is involved and therefore physician collaboration is required for the diagnosis; and b) this condition is well beyond midwives scope of education and training and again a physician should be involved; even physicians would refer PIH to specialists. |
| | Add blood tests for father/donor | Routine practice | The purpose needs clarification |
| Regulated Health Professions Act O.Reg 107/96 (RHPA) | Revise section 4 to authorize midwives to: order maternal postpartum ultrasounds & newborn follow-up ultrasounds | Routine practice | The need for maternal postpartum ultrasounds suggests a major problem and consults with a physician. Ordering is not the issue. Diagnosis and follow-up is the more important variable. More information is needed to understand if the rationale and if the midwives have the appropriate education and training. However, the request for newborn follow-up ultrasounds should not be permitted – this requires diagnosis; with at least two years of diagnostic training, interpretation of ultrasounds and pediatric care, this request may be considered. |
| Ambulance Act | Amend / clarify to allow midwives the proper medical authority during ambulance transport | Routine practice | Ambulance should always go the nearest hospital with the capabilities of meeting the patient needs. This is not about the midwife. This is about the safety of the mother and her newborn. |
| Public Hospitals Act | Revise in order to allow midwives to participate in hospital Medical Advisory Committees decision- | Routine practice | This is possibly the only area where Interprofessional Collaboration is addressed. Midwives should be allowed to participate in the hospital's Professional Advisory Committee |

| Other Legislation | | | RESPONSE FROM THE ONTARIO COLLEGE OF FAMILY PHYSICIANS (OCFP) |
|--------------------------|--|--------------------------|--|
| Action | Proposed Changes | Type of Scope | |
| | making committees and other decision making committees, as well as to provide midwives the same rights to due process in regard to the credentialing process that physicians receive | | and other decision-making committees. The Medical Advisory Committees have been established to oversee medical care rather than the practice of midwifery. |

Conclusion:

The OCFP respects midwives, the College of Midwives of Ontario and the Association of Midwives of Ontario. Moreover, the OCFP is committed to working together to improve care and address the barriers to effective IPC. The OCFP supports all regulated health professionals working to their maximum competence and capability, optimizing their skills to ensure access to high quality care and the regulation of health professionals in a manner that is patient-centered, supports the personal and professional goals of health professionals and maximizes collective resources. However, the scope of practice requests provided by the College of Midwives of Ontario raises many concerns for the OCFP and we recommend that these requests be further explored within the context of interprofessional education, training, collaborative practice and guidelines. The proposed changes call for collaborative discussions about scope of practice, in order to ensure safe and effective care. Midwives cannot work in isolation and changes that promote silos should be discouraged.