

Submission to the Health Professions Regulatory Advisory Council regarding the Midwifery Scope of Practice

I am making this commentary submission to HPRAC as a registered midwife who has been practicing in Ontario for 12 years in mixed urban-rural practice, and as an activist in the midwifery community for 25 years. I am also making this submission as the chief of the first hospital by-laws enshrined, individuated Department of Midwifery formed in the province of Ontario; I have had just over 5 years in this role, having been reappointed for a second term in January of 2008. I would like to address three general areas regarding the College of Midwives of Ontario submission to HPRAC.

Changes to the *Public Hospitals Act*

In 2002-2003, St. Joseph's Health Care, London and London Health Sciences Centre made a decision, after consultation both with the midwives credentialed at that time and with other key stakeholders within the hospital, and a two-day external review, to establish a stand-alone Department of Midwifery. The Department of Midwifery for the London city hospitals was, with appropriate legal consultation, enshrined in what were renamed the Professional Staff By-Laws, to acknowledge and reflect non-medical credentialed staff (including dentists and midwives). The Chief was selected as all hospital chiefs and academic chairs are, through a selection committee which reviewed applications and interviewed suitable applicants. As Chief of Midwifery for the London hospitals, I have a voting seat on the Joint Medical Advisory Committee and, as well, have served a two-year term on the Medical Advisory Committee Executive for the hospitals (a body which establishes agendas for the broader MAC meetings and is tasked with decision-making over the summer months when the MAC does not meet). As well, I take part on all hospital committees pertaining to perinatal care in the city of London, and have played a role in both the functional planning and design of the new perinatal unit which will open at London Health Sciences Centre in 2010. As Chief, I am, of course, responsible for quality of care issues within my department and sign off all applications for credentialing within my department.

With over five years of experience serving in this position, I can offer a unique perspective regarding the vital importance of Departments of Midwifery within hospital structures. Although the College of Midwives' stated rationale for the mandating of departments of midwifery includes reasons such as supporting midwives in providing maternity care to full scope and ensuring timely access to care, there are other equally important reasons for having autonomous departments of midwifery. Because chiefs of departments are responsible for quality of care issues, creating departments of midwifery establishes clear and direct accountabilities with respect to the care provided by midwives within hospitals and thereby enhances patient safety. My experiences since assuming the responsibilities of this role is that there are now clear mechanisms in place to deal not only with complaints and incidents but to establish an understanding with other health professionals regarding the scope of midwifery practice and the philosophy of care. Having a formal place at the table has translated into the ability for interprofessional issues to be resolved far more easily and expeditiously and into integrating a midwifery perspective into the entire system of perinatal care. At the same time, being involved

at the administrative level means that I can also educate my department members more fully on hospital systems and structures, which assists them in understanding why some processes occur the way they do, and some of the limitations that arise from the present conditions in health care. Further to that, the flow of information to department members has been far more timely and pertinent than when midwives were housed within the department of family medicine.

I would argue that having Departments of Midwifery in hospital structures large enough to support individuated departments is critical to the safe provision of care for women having midwifery care in the hospital setting. Therefore, it is not simply a matter of “allowing”, as the College of Midwives of Ontario suggests, midwives to participate in decision-making bodies, but mandating it, so that midwifery care can be properly integrated into perinatal care within hospitals. Whether this is accomplished through revisions to the Public Hospitals Act or through other mechanisms or bodies, it does need to be acted upon. I would suggest that perhaps the Ontario Hospitals Association be involved actively in this discussion.

Changes to Clinical Scope of Practice

There are multiple suggestions for change to the clinical scope of practice for midwives, the majority of which I support. In particular, it is imperative that midwives be permitted to prescribe the measles, mumps and rubella vaccine in the postpartum period. Many hospitals now have the administration of the MMR to non-immune women (apart from those requiring Rh Immune Globulin) in the postpartum period as part of their routine of care. Currently, this requires midwives to obtain an order from a physician in order for this to occur. This creates extra work for both midwives and physicians in order that this essential public health maneuver occur. Further to that, my midwifery practice, for example, provides care to many women who do not have family physicians (there are, for example, approximately 30,000 people in London, Ontario without access to regular primary care) and/or who are not insured. In particular, we care for many women in an Amish community in the Norwich district which had a large rubella outbreak in 2004 (and now is having an outbreak of mumps in the same non-immunized Dutch church community adjacent to the Amish). The Amish community rarely utilizes primary care and would more readily accept immunization from their midwives than from unfamiliar health care providers. Similarly, we care for low-German Mennonite women who are very transitory in their living conditions, who are often uninsured, and who also rarely have access to family physicians or other primary care providers for immunization.

Prescriptive authority for antibiotics for specific situations as specified by the College of Midwives is also an integral part of the provision of good care for women. In particular, delay in treating urinary tract infections, asymptomatic bacteriuria, or mastitis can create even greater medical problems during pregnancy or in the postpartum period. Delays in treatment, however, are routine, especially when the only access to primary care is a walk-in clinic. It is also not an infrequent experience, in that setting, for pregnant women to be denied treatment for asymptomatic bacteriuria, because of lack of obstetrical knowledge on the part of physicians in walk-in clinic settings. Prescriptive authority for antibiotics will also bring midwives in Ontario to equivalency to midwives in other provinces where midwives are regulated.

I would suggest that hormonal contraception, as well as IUD insertion, should be part of routine, not extended, practice for midwives. Early postpartum is an ideal time for IUD insertion (which is part of the scope of practice for nurse practitioners, and for midwives in other jurisdictions); in our practice, it is tragically frequent that women who desire reliable birth control are denied it because we cannot provide it, and they have no access to primary care to get it. By the time they can obtain an appointment with a gynecologist, they may well be pregnant again.

Midwives should also have, as part of scope of practice, the ability to order, under prescribed circumstances (such as uncomplicated post-term pregnancy or prelabour rupture of membranes), induction or augmentation of labour. This would permit the accountabilities with respect to most responsible provider to be clean and direct; further to that, this would also enhance a registered midwife's ability to participate in multidisciplinary call systems in collaborative care systems.

Being able to provide the full scope of maneuvers for neonatal resuscitation will make midwives in Ontario equivalent to midwives in other provinces. The ability to perform these skills is particularly crucial in smaller volume settings where respiratory therapy is not routinely available, or in homebirth settings in the event that a baby would require on-going positive-pressure ventilation during transport.

I also support the changes to legislation that will ensure that clinical actions that midwives currently do will be consistent with the law. In particular, a rectal examination is part of a thorough assessment of perineal laceration and also part of post-repair assessment, and it would be clinically irresponsible not to do it in the course of the provision of care. It is also imperative that legislation with respect to the Ambulance Act be refined and clarified in order that women are directed to the most appropriate centre for care, not just the nearest hospital, which may not be able to provide the proper care.

I also support caesarean section assist for midwives. I have personally been involved in urgent caesarean sections in community hospitals which have been unduly delayed by the need to wait for a physician to come in from the community to assist. Especially in rural settings, the ability for midwives to perform caesarean section assists will enhance the safety and quality of care for labouring women.

There are two areas which I do not support the suggested changes. First of these is the repair of fourth degree lacerations. The repair of fourth degree lacerations is a complex surgical procedure that is rarely done even by family physicians, and must be done correctly in order to ensure perineal integrity. In the course of the care of low-risk women, midwives will rarely encounter fourth degree lacerations (in 12 years of practice, I personally have never had a woman sustain a spontaneous fourth-degree laceration; in the 11 years of this practice with several thousand births, we have had perhaps two) and therefore will not have the volume of clinical experience required to repair them. At the same time, fourth-degree lacerations are rarely clinical emergencies; hemostasis can be secured if necessary and women transported for proper repair by an obstetrician or surgeon. On the other hand, the College of Midwives of Ontario has not addressed the issues of periurethral laceration repair, currently prohibited by legislation. The definition of periurethral laceration has not been clearly delineated for the

purposes of legislation; although lacerations clearly involving close proximity to the urethra should be expertly repaired, often “periurethal” lacerations are lateral to but not particularly close to the urethra, and are easily repaired. This area, however, is highly vascular and women can lose a significant amount of blood if hemostasis is not quickly achieved by repair, which could pose a risk either in the home setting or in hospitals where there is not in-house obstetrical coverage. I feel that this should also be reviewed and taken into consideration in the scope of practice review.

The second item with which I disagree, regarding clinical scope change, is the performance of fetal scalp pH. If a continuous fetal monitor strip is abnormal enough that a scalp pH is being performed, then obstetrical consultation should already have been obtained, in the event that surgical intervention is urgently required.

I also support the changes to laboratory testing for midwives, but would suggest that free T3 and free T4 be added to this list. Our practice, in part because we care for a large number of women with no access to primary care, has been routinely screening women for thyroid disease for several years now, and has identified a number of pregnant women with previously undiagnosed disease. The ability to order the tests for complete diagnosis facilitates faster referral to endocrinology for proper management, which benefits both women and their fetuses.

Active Practice Requirements

Although they do not require changes to legislation, I highly encourage the College of Midwives of Ontario to make the changes in standards and regulations to enhance the integration of midwifery into the maternity care system in Ontario and to increase retention in the profession. These include removing the requirement for two midwives at every birth (making us consistent with other provinces in this regard) and revising the active practice requirements. In particular, consideration must be given to creating categories of registration that do not place limitations with respect to birth attendance in order to remain registered. There must be a means of accommodating and respecting the depth of clinical knowledge and expertise that resides in late career midwives who are no longer able to practice in the physically demanding model that we currently have, and to be able to benefit from this in administrative or in non-intrapartum clinical settings.

Although the College of Midwives of Ontario describes midwifery as inherently collaborative, true collaboration and community responsive models of care for childbearing depends upon flexibility in the model of care and in redefining registration for midwives. In order that midwives contribute effectively to the provision of maternity care in an era of reduced provider resources, we must have the ability to truly collaborate, while at the same time preserving the autonomy of our profession.

Respectfully submitted,

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