College of Midwives of Ontario - Response to the Ontario College of Family Physicians Regarding the CMO's Scope of Practice Submission
August 19, 2008

Introduction

The College of Midwives of Ontario (CMO), as the regulatory body for the profession of midwifery in Ontario, is committed to working collaboratively to improve maternity care to women and infants and to address barriers to interprofessional collaboration. The CMO appreciates the opportunity to respond to the Ontario College of Family Physicians' (OCFP) letter regarding the proposed amendments to midwives' scope of practice.

Many of the concerns raised by the OCFP related to the proposed changes to the legislation and controlled acts are the same or similar to concerns raised by the Ontario Medical Association. Given this, in order to respond to the OCFP's specific concerns and to attempt to be brief in this response, the CMO would respectfully direct the reader to the CMO's August 6th, 2008 response to the OMA.

Response to the OCFP's Concerns

The OCFP indicates that they are disappointed "*to see that the College of Midwives is not requesting changes to make it easier for them to work with other providers*", and expresses the belief that the CMO's proposed changes to the midwifery scope of practice "*seem to be aimed at further distancing midwifery from their professional colleagues.*" *(pg. 1)*

The CMO takes the opposite view, believing that the proposed changes will better equip midwives to be full and active members of interprofessional care (IPC) teams and to operate effectively in interprofessional settings.

The Multidisciplinary Collaborative Primary Maternity Care Project (MCP^2), a multi-disciplinary project funded by Health Canada in 2006, which included professionals from all of the relevant disciplines and that undertook a comprehensive analysis of how best to develop interdisciplinary teams for the delivery of maternity care, was used extensively to inform the CMO's proposed changes. The definition of the multidisciplinary care model outlined in the MCP2 report states that:

> "The model is designed to promote the active participation of each discipline in providing quality care. It is woman-centred, respects the goals and values of women and their families, provides mechanisms for continuous communication among caregivers, optimizes caregiver participation in clinical decision-making (within and across disciplines), and fosters respect for the contribution of all disciplines."[i]

The proposed changes to midwifery scope will enhance midwives' capacity to provide care to low-risk women and their babies at a level that is similar to a family physician. This will support the recommendation that primary maternity care providers should have overlapping competencies, to better meet the needs of the community while working in interprofessional environments. As is noted in MCP^2:

> It is important for team members to respect each other's scopes of practice and to maintain appropriate standards of care. At the same time, collaborative models offer opportunities to share care and build upon the expertise of others, thus building broader core competencies as a team. Scope of practice may be variable or change over time as providers in the core team acquire new or different skills. Although there are well known inherent contextual barriers to addressing scope of practice issues in the respective jurisdictions across the country, the ability for different professionals to overlap practice functions offer strong benefits to both the providers and recipients of care.[ii]

The OCFP goes on to list a number of key enablers that they believe are critical to moving IPC forward. The CMO agrees with these enablers and would provide the following clarification regarding the College's position in relation to a number of them.

- Compensation and funding

The CMO also recognizes that payment issues may constitute a barrier for some care providers. These issues will need to be considered as part of the discussion of the sustainability of the province's health care system and in relation to the ongoing work required to facilitate effective interprofessional maternity care. They are not, the CMO believes, within the purview of a regulatory college and so were not included in the submission.

- Quality improvement programs

The CMO has a solid record with its comprehensive Quality Assurance Program, which requires annual reporting on a member's fulfillment of a set of rigorous requirements. CMO members have consistently had an excellent level of compliance with this program. The necessary requirements and monitoring related to any expansion of scope of practice will be put in place through the existing QAP to ensure continued member compliance and competence. The QAP facilitates the implementation of practice modification tools, encourages learning from incidents, near misses, adverse events and fosters the use of principles of high reliability organizations (HROs).[iii]

- Interprofessional communication policies, protocols, guidelines

The CMO has a number of guideline and policy documents already in place that support IPC. For example:

- Core Competencies, which include a section entitled "Collaboration with other Caregivers"
- Indications for Mandatory Discussion, Consult and Transfer of Care
- Standard on Shared Primary Care
- Guideline for Shared Care with a Consulting Health Provider
- Guideline for Antepartum Consultation to Anesthesia
- Ambulance Registration for Home Births
- AOM/CMO Consensus Statement on the Model of Midwifery

The CMO's Standard "Indications for Mandatory Discussion, Consultation, and Transfer of Care" sets out the clinical situations in which midwives are required to consult with a physician. This document has been used since the regulation of midwifery as an effective tool to support and guide collaborative care between midwives and physicians. In its report, OMCEP recommended that hospitals use this standard as the basis for local consultation and transfer of care protocols. To that end, the CMO is well situated to provide evidence and experience-based recommendations to HPRAC regarding regulatory features that may enhance interprofessional collaboration between health professions in Ontario.

As the scope of practice for midwives evolves, this standard will be closely evaluated for comprehensiveness and accuracy and changes will be made to ensure that it supports members as they participate in interprofessional collaboration. Changes will be based on research, experience and ongoing evaluation of midwifery practice to ensure the relevance of the standard to safe and effective midwifery care.

- Flexible organizational structures

The CMO thoroughly agrees that organisations need to have the flexibility and capacity to meet local needs and to work with available resources; however this flexibility cannot be translated into individual hospitals being permitted to limit scope inappropriately. Currently, the integration of midwifery into hospitals has been inconsistent; there is significant variation across the province. These discrepancies, which result in inconsistent access to and standards of care across the province, manifest in a number of ways, for instance:

- scope restrictions in excess of CMO requirements (CMO required consultations resulting in transfer of care to an obstetrician);
- transfer of care to an obstetrician for women having an induction or epidural;
- inappropriate roles and tasks for midwives (i.e. nursing functions);
- limiting the number of midwives granted privileges;
- limiting of the number of births attended by midwives;
- restricting midwives' community practice (home birth attendance);
- restricting midwives' care for non- OHIP clients in hospital;
- inconsistent hospital midwifery policies.

- Patient/caregiver involvement

Ontario's model of midwifery embodies the principle of informed choice and recognizes the client as the primary decision-maker.

The OCFP goes on to assert that "*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.*" *(pg. 2)*

The experiences reported by our members and the women and families they serve do not support this contention (see submissions to HPRAC from L. Damore and B. Fulton-Breathat). As noted by these submissions, many members experience scope restrictions that are in excess of CMO requirements. Quite the opposite of adding a layer of safety, these restrictions often result in

unnecessary transfers of care and delays at point of care, both factors that the patient safety knowledge and practice tells us contribute to increased potential for negative outcomes.

Furthermore, given the advancements that have been made in health care, it is unrealistic to assume that the scopes of practice of all regulated health professions, regardless of when and in what context they were developed, remain adequate to address the changing needs of Ontario's citizens. The current scope of practice of midwifery was written over 15 years ago, and no longer reflects evidence-based best practice in primary maternity care, nor does it meet the standard of the scope of midwifery across the country.

The OCFP maintains that their *"recommendations are based on the need to ensure the safety of mother and newborn, first and foremost."(pg. 2)* While the CMO appreciates that this is a primary concern for the OCFP, it should be noted that the role of the CMO is to regulate the profession of midwifery in the interest of public safety, and the CMO believes that it has fulfilled that role for the past 15 years, as well as in the scope of practice submission to HPRAC. This overarching concern with safety is addressed throughout the full submission

The OCFP goes on to raise concerns related to four areas; the CMO response to each is detailed below.

1. Education and training

Pages 55 to 58 of the CMO submission to HPRAC outline the educational component of the proposed amendments. They include a detailed explanation from the midwifery education program (MEP) regarding the plan for integrating the proposed changes into the MEP (see also V. Van Wagner submission to HPRAC). Similarly, the CMO is working with the education programs, as well as the AOM, in the development of a plan to address the learning needs for those midwives currently in practice, with respect to the proposed changes to the scope of practice.

The level of training required for the proposed additions to the midwifery scope of practice is equivalent to that of any primary caregiver attending births. The education that is required is appropriate to this role and to equipping midwives to deal with emergencies that can occur during the course of a normal delivery.

2. Extension of practice into well women and newborn/well baby care and fragmentation of primary care

Well-baby and well-woman care beyond the current scope of six weeks are components of the specialized extended scope of practice area that are being proposed for midwives whose communities may benefit from care in these areas. This proposed amendment is in line with standards of care across the country (e.g., midwives in the Northwest Territories routinely provide well-baby care to their clients for up to one year).

Rather than fragmenting primary care, this expansion would support continuity of care for woman and infants who do not have ready access to family physicians or specialists, particularly in remote and rural communities. Building on the existing established care relationships, these expansions would support midwives in providing appropriate comprehensive care.

Changes related to well-baby and well-woman care will be implemented, as with the other proposed amendments, with the appropriate level of training and rigorous quality assurance.

3. Interprofessional Collaboration and Education

It should be noted that midwives learn early the value and necessity of interprofessional collaboration. IPC is an established mandatory component of the Midwifery Education Program (MEP) curriculum. The MEP uses an IPC approach to teaching as well as including significant IPC content in their curricula (see V. Van Wagner submission to HPRAC).

Currently midwifery students are required to participate in one interprofessional care placement in their third year. Clinical placements have been developed and will be implemented by 2009 to ensure that all third year students will have two placements that are within an interprofessional team or setting. The International Midwifery Preregistration program is working to have similarly comprehensive interprofessional care placements for its students.

4. Physician substitution

The CMO is not proposing that midwives act as physician substitutes. What the submission does propose is that midwives, who are highly trained and experienced specialists in normal pregnancy and newborn care, be authorized to extend their scope of practice to help meet the particular needs of a community. The tasks included in the extended scope of practice will be regulated by the CMO to ensure proper education, as well as the necessary quality assurance requirements.

The CMO recognizes that midwives are not physicians but feels that the existing scope of midwifery practice is outdated and does not reflect the current best-practices in maternity care for low-risk clients, nor does it maximize midwifery's potential to contribute to alleviating Ontario's maternity care crisis. The OCFP's response suggests that that they do not recognize or appreciate the high level and variety of skills that midwives in Ontario possess, along with the intensive education and training they go through to become registered, as well as to maintain registration.

Midwives are a valuable human resource and have a significant role to play in solving Ontario's maternity care crisis. Allowing midwives to work to a broader scope as outlined in the CMO submission, does not amount to physician substitution; rather it represents the effective use of available and appropriate resources. In its report entitled "Strengthening health services delivery: human resources Strengthening nursing and midwifery" the World Health Organization states:

> "In many countries, nursing and midwifery skills are put to limited use, despite their proven cost-effectiveness. Many countries do not capitalize on the evidence that nursing

> and midwifery interventions and the appropriate use of nurses and midwives can drastically increase coverage of basic health interventions."[iv]

The CMO recognizes that the areas where the OCFP feels that midwives are being positioned as physician substitutes are those where an extended scope of practice that goes beyond the routine provision of maternity care for low-risk clients is being proposed. In that regard, midwives will most assuredly be doing more tasks that a physician might also do; however, they will be performing the tasks in an effort to meet the needs of communities where other practitioners are not available. In urban centres, where there are a sufficient number of adequately staffed maternity care teams that include midwives, nurses, respiratory therapists, anesthesiologists, family doctors, obstetricians and surgeons, the extended scope skills will likely not be necessary.

Finally, it is important to note that individuals entering the midwifery profession are currently the only consistent, predictable, and reliable source of the maternity care workforce and are therefore a significant part of the health human resource shortage solution. The proposed changes would only be a "*band-aid solution*" as the OCFP suggests if their intent is to maintain the status quo of the current system. The CMO believes that this is not feasible, desirable, or even possible. Ontario is facing a maternity care crisis. The number of family physicians providing maternity care services is dropping steadily, while the number of babies being born is increasing. Health Force Ontario has indicated that there is a ministerial commitment to "developing new provider roles and new models of care that will make the best use of all our skills and resources"[v] as part of the effort to resolve sustainability issues across the health system. The proposed changes to the midwifery scope will support the development of new roles by allowing midwives to provide needed care in many of the province's underserviced communities. Moreover, it will support a better balance between primary and specialist care across the province, ensuring that the other obstetrical resources are better used.

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[i] MCP2 Guidelines for Development of a Multidisciplinary Collaborative Primary Maternity Care Model. Available online at
http://www.mcp2.ca/english/documents/D-FinalGuidelinestoModelDev1May06.pdf

[ii] Ibid.

[iii] Ibid.

[iv] World Health Organisation Executive Board Report. Strengthening health services delivery: human resources Strengthening nursing and midwifery. Available online at
http://ftp.who.int/gb/archive/pdf_files/EB107/ee6.pdf.

[v] http://www.healthforceontario.ca/HealthcareInOntario/About_Ontario_Health_Care.aspx