

Annie Schiefer, Project Manager
Health Professions Regulatory Advisory Council
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Dear Ms. Schiefer,

I wish to respond to the CMO's submission to the HPRAC regarding the changes to our scope of practice. I have been practicing as a Registered midwife in Ontario for 12 years, am also a sessional instructor for the Midwifery Education Program, and have 8 years experience as the Head of the Service of Midwifery at Sudbury Regional Hospital.

The changes suggested by the CMO are critical for the profession of Midwifery, and have significant cost saving implications for the Province of Ontario. I am particularly concerned about midwives having the ability to prescribe antibiotics. 15-40% of women swab positive for beta hemolytic streptococcus, and require intrapartum antibiotic prophylaxis. This management of GBS at term is well documented and established practice. It is an ongoing source of frustration to both midwives, and our physician colleagues that we must consult a physician to obtain the antibiotic orders for this most routine practice. The obstetricians of the Sudbury Regional Hospital have repeatedly refused to consider standing orders on the advice of their insurers. As a busy practice of 8 midwives, this means we are often waking the obstetrician on call 13 or more times per month just for antibiotic orders. This is a single practice. It is a complete waste of health care dollars to involve a second practitioner for this most basic aspect of care. Additionally, it undermines our status as independent health professionals. Our family practice colleagues who practice obstetrics and have a nearly identical clientele, are able to treat their patients without involving another practitioner. Midwives cannot.

The issue of antibiotics is not unique to intrapartum care; in the prenatal period we are able to order the laboratory testing to identify patients with urinary tract infection and sexually transmitted infections, yet we cannot treat them. In a community where there is a critical shortage of family doctors, this means that we are often sending women to ambulatory care clinics with their lab results in hand to obtain the appropriate antibiotics. It costs the health care system financially for this to occur, and again undermines our role as primary care practitioners. I cannot count the number of times I have had my clients question why as their midwife I am considered competent to order the testing but not to treat them. They also see it as a fragmentation of their care, a second cost to the health care system their tax dollars pay for, and an inconvenience. The situations I am describing are not high risk, and do not necessitate the involvement of a specialist, they are routine daily occurrences that waste time and resources.

The ability to order MMR vaccine for postpartum clients is also a critically needed change to our scope of practice. Rubella infection in pregnancy can have devastating consequences for the developing fetus. Midwives are considered competent to test the pregnant woman's immune status. However, since the vaccine cannot be administered in pregnancy the only option is to immunize in the postnatal period. The ordering of the vaccine is not currently within our scope of practice. This means that the midwife must either consult with a physician to obtain the order (a waste of health care dollars and physician resources), or refer the woman to the local immunization clinic at the health unit. In our community, due to the lack of family doctors this is frequently the only option,

particularly for home birth clients. Unfortunately despite repeatedly reminding new and busy mothers, sometimes this immunization doesn't occur and they present with their next pregnancy, still vulnerable to rubella infection. This is not good health policy. Midwives follow women closely in the postnatal period. We already have the skills to recognize adverse reactions, and carry Benadryl and epinephrine to treat them. We can administer Rh immunoglobulin (a blood product no less), but not MMR vaccine. This makes no sense, and increases the financial burden to the health care system.

The final point I would like to make concerns participation on Medical Advisory Committees. In the 12 years that I have worked as a midwife (including 8 years as the Head of the Service of Midwifery), I would have to say one of the greatest barriers to the acceptance of midwives has been the second tier role we are permitted within the hospital organization. I realize that in London Ontario their hospital has chosen to have a Department of Midwifery and recognize midwives as being equal to medical doctors. However, for the rest of the province, as long as it is considered acceptable for midwives to not have a voice at the medical advisory level, then midwives will continue to be viewed as lesser practitioners than medical doctors.

Thank you for your time and consideration of my thoughts and the CMO proposal.

Sincerely,

Buffy Fulton-Breathat.

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