

Synthesis Paper

**Scope of midwifery practice in Ontario:
working within the boundaries of “normal”**

By: Christy Battye
Supervisor: Vicki Van Wagner

Midwifery Education Programme
Ryerson University

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Abstract

Scope of practice is an important and dynamic aspect of the midwifery profession in Ontario. In order to discuss appropriate scope and its boundaries, this paper explores the role of the midwife and the definition of normal. Ontario midwives are considered to be primary care providers who care for healthy, low-risk, pregnant women. The definition of normal is dynamic and despite the apparent complexity, midwifery has the potential to promote a level of fluidity that recognizes the individuality of a woman's labour and birth.

The boundaries of normal are essentially outlined in the College of Midwives of Ontario (CMO) document "Indications for Mandatory Discussion, Consultation and Transfer of Care" (IMDCTC), which is a standard that was adopted as part of the provincial process of legal recognition and regulation of midwifery. Midwives often refer to the IMDCTC when discussing their scope of practice, although not all practice to its full extent. In some cases, hospital policy requires that midwives transfer care to a physician in a number of additional situations. There are currently 63 practice groups in Ontario with privileges at approximately 64 hospitals, but it is difficult to ascertain whether the CMO standards accurately reflect the actual practice of midwifery in the province. While some practices have achieved what has come to be called "full-scope", others are working to attain it. Still others have begun advocating for its expansion with support from the CMO and the Association of Ontario Midwives (AOM).

Scope of practice has many implications for practicing midwives who have differing opinions and preferences for a particular way of practicing. Midwifery students are also impacted by varied scope, which can have an effect on both their skill development and their core values

and beliefs about childbirth. The views and beliefs of both practicing and student midwives shape the way scope of practice is implemented and protected in Ontario.

Keywords: midwifery, scope of practice, Ontario midwifery, normal birth

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“It is no wonder that midwifery practice, which seems clearly based on a simple philosophy, is complex, difficult to articulate, and subject to misunderstanding”

Tekoa King (1:448)

Introduction

Scope of practice is an important and dynamic aspect of the midwifery profession in Ontario. Although it is most broadly defined by the Midwifery Act and the Regulated Health Professions Act, the term is often used to reflect the College of Midwives of Ontario (CMO) document “Indications for Mandatory Discussion, Consultation and Transfer of Care” (IMDCTC), particularly when referring to practices that have “full-scope” versus “limited scope”. (2) The issue of scope is of particular interest to most practicing midwives and midwifery students and it is worth exploring the concept as well as the reality for both groups. Many midwives have opinions and preferences for a particular way of practicing and these views help shape the midwifery profession. Debate about scope of practice is fundamental to political action and defining the midwife’s role in the larger context of maternity care in Ontario and Canada.

In order to effectively discuss the scope of midwifery practice in Ontario, one must first define what is meant by the term, both as it is used in the literature and in daily midwifery practice. *Scope of practice* can have a variety of meanings among midwives, consumers and other health professionals. The term was jointly defined by the Health Professions Legislative Review (HPLR) and the Association of Ontario Midwives (AOM) in 1988 as “the assessment, monitoring and provision of care during normal pregnancy, labour and the post-partum period and conducting spontaneous normal vaginal deliveries” and includes a number of specific, licensed acts. (3:163) It has also been defined, albeit vaguely, as “encompass[ing] the activities for which its practitioners are educated and have lawful authority to perform”. (4:261) The final

definition that appears in the *Midwifery Act, 1991* expands upon that described by the HPLR and AOM and is as follows:

“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 provisions of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous, normal, vaginal deliveries.” (5)

This definition clearly restricts midwifery care to pregnant women and their newborns.

Midwives are not permitted to provide care to non-pregnant women (beyond the normal postpartum period), men or children according to this definition.

Scope of practice is often misunderstood and misrepresented. The term is used not only to describe the practice of midwives, but also to identify clients that are appropriate for midwifery care, to identify the skills that a midwife should or should not possess and to assist in the development of clinical practice guidelines. (6:465) As Kerri Schuiling and Joani Slager note, it is used to describe the range of professional practice in a broad sense, but more narrowly, and perhaps more casually, it is used to describe what a midwife can or cannot do. They argue that the range of interpretations of the term is due to the emphasis of midwifery practice on normal, healthy women (see discussion of defining “normal” below), as well as the evolving nature of scope. Schuiling and Slager clearly articulate that *scope of practice* “does not define a level of practice but identifies the range or extent of a midwife’s practice within specified limits”. (6:466) Scope is defined not only by the inflexible boundaries of regulation and governance (such as the midwifery-related acts and regulations mandated by the Government of Ontario), but also by flexible clinical parameters such as practice setting, community standards and experience of the midwife. (6:465) The standards, policies and guidelines mandated by the CMO are slightly more flexible than the provincial regulations in that changes can be

implemented through the College itself, rather than through provincial parliament. (7). *Scope of practice* is also determined by the setting and demographics of the population in which the midwife works. (8:524) The flexible boundaries, in particular, influence the variations in scope of practice in Ontario, the implications of which will be discussed in this paper.

Defining “model of practice” and “philosophy of care”

The Ontario midwifery *model of practice* reflects the basic tenets of midwifery. These tenets include continuity of care, informed choice and choice of birth place and are essential to the model of practice. The model is relatively unique to Canada and admired on an international level, and it was developed, in part, to preserve the nature of midwifery practice as it existed prior to legislation and to integrate emerging international trends in the profession. (9:86)

Continuity of care reflects the availability of a small group of midwives (no more than four) to a client during all trimesters of pregnancy on a twenty-four hour, on-call basis. The tenet of informed choice recognizes the pregnant woman as the ultimate decision maker, encouraged and supported through her decisions by her midwife. Choice of birthplace reflects the capability of a midwife to provide care in all settings, while identifying the need to encourage out-of-hospital birth as a way of preserving and promoting childbirth as a normal, physiological process. (10:2) The model of practice also serves to protect against medicalization, disintegration of the client-caregiver relationship and disempowerment of the woman and her family. (9:86)

The *philosophy of care* in Ontario is reflected in the model of practice, in that it respects pregnancy as a normal, healthy event in a woman’s life. It recognizes the diversity of women in the province and their shared responsibility for their own care. The interests of the woman and her baby are regarded as compatible and women are supported to “give birth safely, with power

and dignity”. The woman’s social, cultural, emotional and physical needs are addressed in a personal and non-authoritarian way and the midwife educates and counsels, as needed, to empower the woman to make informed choices. (11) The philosophy of care is, essentially, an expression of the beliefs and values that are held by the CMO and is common to the philosophies held by midwives around the world. (12:112-7)

Definition and role of the midwife

In order to assess the appropriate scope of practice for midwives, it is worth reviewing both the definition and role of the midwife, as well as the definition of *normal*. By establishing an understanding of these terms, the Ontario scope of midwifery practice and its implications for practicing midwives and students can be explored.

Midwives specialize in providing care for normal labour and birth. The International Confederation of Midwives defines a midwife as:

“A person who, having been regularly admitted to a midwifery educational program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.” (10, 13:69, 14:1)

This definition accounts for the wide variations in the training and tasks of midwives between countries. It acknowledges that different education programs exist and that midwives may work in hospitals under the direction and supervision of obstetricians. Thus, care in normal birth may ultimately fall under an obstetrical department, with poor differentiation between low- and high-risk pregnancies. (15:5) This definition, however, does not give any indication of the detailed scope of practice for midwives, but does go on to state:

“The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.” (16)

The details of appropriate scope of practice remain vague in this definition to allow various jurisdictions to define scope according to the social, political and health care environment in which midwifery is practiced. The international definition leaves it up to national, provincial and even local organizations to establish appropriate boundaries. In Ontario, this includes the CMO standards, policies and guidelines as well as local hospital policies and administration.

In Ontario, midwives are generally considered primary care providers in that a referral from another health professional is not required and they can provide prenatal, intrapartum and post-partum care in an autonomous fashion, fully responsible for their own clients. (10:2) The concept of primary care, however, may be two-fold, as Nancy Sullivan describes. From a “social justice” view, primary care providers aim to care for underserved populations: poor, rural or otherwise ignored or abandoned communities. The “industrial efficiency view”, on the other hand, sees the primary care provider as the provider of the majority of basic services and gatekeeper to specialist referrals. (17:450)

Ontario midwives function according to the industrial efficiency view in that they can refer to specialists when required, but access to specialists is not limited to midwifery referrals (that is, midwives are not truly gatekeepers to specialists). The philosophy of care and model of practice, however, also strongly reflects the social justice view. Moreover, midwives themselves are likely to identify with the social justice view of primary care. (17:451) The role of obstetricians in Ontario, however, can confuse this picture as they also often work as primary care providers even though they are, essentially, specialists in high risk pregnancy and birth. (Arguably, midwives might also be considered specialists in normal, low-risk pregnancy and birth.) This obstetrical primary care role developed during the early twentieth century as childbirth increasingly became considered a pathological event requiring medical intervention. The perception that the hospital environment produced healthy mothers and babies was perpetuated and obstetricians became the front-line workers of maternity care, regardless of a woman's individual risk. (18:18) This role has become even more significant in recent history, as there has been a great reduction of family physicians providing maternity care and obstetricians have responded, providing a wide range of primary intrapartum care to Ontario women. (19:26-27)

Defining "normal"

As reflected in the definition of a midwife (above), it is often stated that midwives are the "guardians of normal", or that they provide care for normal, healthy, low-risk, pregnant women. (20:85, 21:370) They are considered to be the experts and lead caregivers in normal childbirth, especially in countries such as England and The Netherlands. (22:4) It follows, then, that without defining the term *normal*, one cannot effectively discuss the boundaries of midwifery care.

Moreover, one cannot discuss *normal* without considering the wider context of birth itself.

(23:87)

Defining *normal*, however, is at best difficult and at worst impossible. There is no real consensus on the meaning of the word, but it may be understood as:

- “the way things are under normal circumstances;
- usual, conforming to the usual standard, type or custom;
- occurring naturally, maintained or occurring in a natural state” (24:21)

The understanding of *normal* is further muddled when interchanged with the term *natural* (which is also complex and difficult to articulate), as in the third definition suggested above.

Lindsay Reid asks, “[w]hile a natural birth will usually be normal, are all normal births totally natural?” She compares the concept of *normal as a naturally-occurring phenomenon* with the definition of *natural childbirth as one without any medical intervention*. With direct interchanging of the terms *normal* and *natural*, for example, breech births, twins and even maternal or neonatal deaths, which do occur naturally, would be considered normal, while the use of episiotomy, for example, would not. (24:25) Debby Gould also notes that many midwives believe natural birth to be normal, but that normal birth need not be natural. She also identifies the differing definitions of normal used by different health professionals, including obstetricians, epidemiologists, psychologists, anthropologists, sociologists and midwives. In particular, obstetricians define normal birth only in retrospect, while midwives tend to define it by the woman’s experience. (25:420)

The Royal College of Midwives (RCM) suggests that *normal childbirth* might include a spontaneous onset of labour; consideration of labour as a continuum; holistic, using alternative

coping methods for pain; spontaneous rupture of membranes; and a calm, non-threatening environment where the fetus is monitored only intermittently. *Normal* does not include interventions such as induction or augmentation of labour, pharmacological pain relief, artificial rupture of membranes, institutionalization of birth, continuous fetal monitoring, routine vaginal examinations or episiotomy. (24:22) The RCM Position Statement defines normal birth as “one where a woman starts, continues and completes labour physiologically at term”. (24:23)

Similarly, the World Health Organization (WHO) defines normal birth as:

“spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition” (15:3)

The WHO goes on to state that, in general, between 70 and 80% of all pregnant women may be considered to be low-risk at the onset of labour. (15:4) The New Zealand Ministry of Health reported a normal birth rate of 68.7% in 2001, despite the lack of a definition for normal birth; the only births that were excluded were those that were facilitated by caesarean or instrumental delivery. (23:87) A 2001 survey conducted by the National Health Service (NHS) in the United Kingdom showed that 62.3% of births that were considered “normal” had received some degree of intervention; the question arises whether *any* interventions can be classified as normal. (22:4) From such a perspective, Ontario midwives can already be considered to work well beyond the boundaries of normal; they can, for example, order routine ultrasounds and non-stress tests, and they can perform amniotomies and manage oxytocin inductions or augmentations. (26, 27) Thus, the very dynamic concept of *routine* (or *usual*) also greatly influences the boundaries of normal and given that interventions are perhaps more likely to

become routine rather than be eliminated from care (at least initially), the boundaries of *normal* might also tend to expand rather than retract.

Despite the apparent complexity of defining *normal*, midwifery has the potential to promote a level of fluidity that recognizes the individuality of a woman's labour and birth. The boundaries of the definition are continually re-established, rather than pathologizing the woman's labour and attempting to correct common (read: normal) deviations through intervention. (23:87-8, 95) Moreover, normal birth must be seen as a continuum, without differentiation between the labour and the delivery. (23:96)

Scope of practice and the CMO guidelines: the real face of midwifery in Ontario

While scope of practice can be understood and defined on several levels, perhaps the most functional, or practical, level centres on the specific, clinical boundaries within which a midwife practices. In Ontario, these boundaries are clearly outlined in the CMO's Indications for Mandatory Discussion, Consultation and Transfer of Care (IMDCTC). (2) The IMDCTC clearly define the variety of situations that require midwives to discuss care plans with each other or with other health care providers (specifically physicians or other medical specialists) or to transfer care to a physician (such as an obstetrician or pediatrician). They cover the entire course of midwifery care, from the initial history and physical examination through labour and birth to the end of the six weeks of postpartum care. Midwives often refer to the IMDCTC when discussing their scope of practice.

History and development of the CMO Indications

The Ontario model of care and the associated indications were formalized as part of the integration of midwifery into the health care system, although they had been developed and voluntarily used by practicing midwives prior to regulation. (personal communication-Vicki Van Wagner, March 2008) Several key events occurred that influenced midwifery legislation in Ontario, including the Health Professions Legislation Review (HPLR), which allowed midwives to formally state their model of practice in their request for regulation as an official health care profession. (18:19-20, 28:184) This led to the development of the Task Force on the Implementation of Midwifery in Ontario (the “Task Force”), whose mandate included the development of recommendations for midwives’ scope of practice. (28:184) The professional and governing body at the time, the Association of Ontario Midwives (AOM), argued that the scope of midwifery practice should meet the International Definition of a Midwife (described above) and the Task Force agreed. (18:20, 20:85,88, 28:184,185) The Task Force also recommended that the midwives should be self-regulated and that their scope of practice be related primarily to the reproductive cycle and include the delegation of some controlled, medical acts. (18:22, 20:89) Most relevant to this paper, they recommended that the midwifery standards of practice include detailed criteria for consultation and referral to a physician, even going so far as to recommend a minimum of two mandatory prenatal visits with a physician for all clients (this recommendation was not implemented). For reference, the Task Force included a “List of Indications for Specialist Care in The Netherlands” in an appendix of their report that provided an example of consultation and referral criteria for autonomously practicing midwives

and to highlight the fact that the Dutch indications were already known to Ontario midwives. (20:89,411, personal communication-Vicki Van Wagner, March 2008)

The development of the IMDCTC by the newly appointed Interim Regulatory Council (IRC) (the forerunner to the CMO) was based on standards previously developed by the AOM and extensive review of various international guidelines and the best evidence-based research available at the time. (18:22) The IRC was an inter-professional committee, which included family doctors and obstetricians. They circulated the IMDCTC to all major professional bodies, including the Society of Obstetricians and Gynecologists of Canada (SOGC), the Ontario Medical Association (OMA), the College of Physicians and Surgeons of Ontario (CPSO), and the Canadian Pediatric Society (CPS), among others. It was carefully developed to support the autonomy of midwives and to respect the ability of midwives to use their clinical judgement and available evidence in assessing an individual woman's need for consultation or transfer of care. It also provided a clear framework for other professionals, such as physicians and nurses, and the public to understand the scope of midwifery practice in Ontario. This document also presented a foundation for the integration of midwives into the hospital environment and effectively defined *normal* for midwifery practice in the province. *Abnormal* was identified by those indications requiring a transfer of care. (personal communication-Vicki Van Wagner, March 2008)

The AOM had recognized the inherent difficulty in defining *normal* and the possible restrictions in scope that could be created. It was accepted that a simple or single definition did not exist and that midwives were appropriate caregivers for the many variations of normal. (personal communication-Vicki Van Wagner, March 2008) It is perhaps more important to consider midwives as the "guardians of normal" in that they aim to keep a woman's pregnancy,

labour and birth *as close to normal as possible*, rather than only providing care for those women that fall within a restrictive definition. Sue Crabtree, however, notes the potential internalization of medical intervention with the idea of keeping birth “as close to normal as possible”. She argues that there is a subtle, yet important, difference in the idea of bringing birth “back to normal” in response to interventions. (23:96) As Kerri Schuiling states, “[a]lthough midwives are the experts in the care of essentially normal, healthy women, normality itself is not a requisite for care”. She goes on to state that the role of the midwife in higher-risk situations is to optimize normality rather than abandon it. (6:467) The American College of Nurse-Midwives has gone so far as to replace the term *normal* with *essentially healthy* in their document “Core Competencies in Nurse-Midwifery”. (29:532) This approach to *normal*, then, allows greater accessibility of midwifery care to women; those who require oxytocin augmentation, for example, are not excluded from care and can benefit from the basic tenets of continuity of care, informed choice and possibly choice of birthplace. In essence, as discussed above, *normal* is not defined by concrete boundaries, but by guidelines that the midwife can apply, as needed, to individualize a woman’s care. (23:98)

With legislation, midwives experienced what may be the most significant increase in their scope of practice, as well as great enhancement of the model of care. Women became free to choose midwives in either the home or hospital setting while making informed choices with the same caregiver throughout their pregnancy, labour and birth. Midwives and their clients no longer had to concede to physicians as they passed through the hospital doors, but were, instead, recognized professionals in the Ontario health care system. (28:187)

The CMO Indications in practice

While the IMDCTC provide comprehensive guidelines to midwives' scope of practice, not all midwifery groups practice to their full extent. For example, some practices must transfer care to a physician (usually an obstetrician) if a woman requires oxytocin augmentation. While augmentation is not specifically listed in the IMDCTC, possible reasons for requiring augmentation are explicitly stated, such as "prolonged active phase", which requires consultation with a physician. The administration of oxytocin by intravenous infusion by the midwife is permitted by the CMO, needing only an order by the consulting physician; a transfer of care is not required. (2:6, 27:1) Likewise, cervical ripening and/or oxytocin induction might be necessary for a "documented post-term pregnancy" and, again, requires only a consultation and midwives are licensed to administer cervical ripening agents, in addition to intravenous oxytocin. (2:5, 27:2) The CMO guidelines provide such room to allow midwives to manage this care under the order of the consulting physician, but some Ontario hospitals require that the midwife transfer care completely. Other common scope limitations might include management of epidural analgesia or delivery of infants between 34 and 37 weeks` gestation, both of which require only a consultation, as well. Although management of breech presentation and twins could also be considered in this category, the clinical considerations for these conditions are significantly different and are not discussed in this paper. (2)

There are currently sixty-three midwifery practice groups in Ontario with privileges at approximately sixty-four hospitals. (30, 31) It is not clear how many of these midwifery groups practice to their full-scope, and for those that are practicing with a limited scope, information is not readily available to indicate what situations require midwives to transfer care and how often

this is occurring. The CMO has stated a commitment to support midwives in achieving and working within the full scope of practice, however the College does not have the authority to mandate this requirement at all hospitals. (32:4) Without any clear indication of how many midwifery groups are working to their full scope, it is difficult to ascertain whether the CMO Standards accurately reflect the actual practice of midwifery in Ontario. A review and publication of this information might be of great value in forging the way ahead now that midwives have been practicing legally under these guidelines for over a decade.

The CMO does provide assistance to midwives in addressing issues that arise when hospital policies differ from College Standards, which strongly promote the principle of informed choice. The CMO has provided a copy of the IMDCTC to all hospitals where midwives have privileges. A copy of the 2001 Coroner's jury recommendations was also included; this document recommends that the IMDCTC should be used as the basis for hospital policies for midwives. Midwives are encouraged to notify the CMO in writing when such hospital restrictions exist and an advisor may be provided to assist in resolving the situation. The CMO also states that clients should be informed of hospital policies that restrict the scope of midwifery practice to encourage them, as interested members of the community served by the hospital, to advocate for full scope. Clients are entitled to the care outlined in the IMDCTC and CMO Standards; limited scope denies them this right, which is essentially mandated by the Ontario Ministry of Health and Long-Term Care (OMHLTC). (33)

The CMO also provides several strategies for achieving full scope of practice, including meetings with Chiefs of Staff, Chiefs of Obstetrics and hospital boards, support and guidance of consumer advocacy groups and conducting facilitated dialogue with hospital representatives. It

also recommends that the practice group keep the Ontario Midwifery Program (OMP) of the OMHLTC informed of barriers to achieving full scope. (33)

Given that the College so clearly advocates that midwives should practice to their full scope, one might question how and why practice groups are working within a limited scope. It would be interesting to assess the limited-scope practices based on whether they were created prior to or with legislation, or if they are newer practice groups that have been formed since legislation. Ivy Lynn Bourgeault raises the question of how the relatively fast integration process may have impacted midwifery philosophy and practice. (28:173) She discusses how organized efforts to achieve integration often necessitate a degree of sponsorship from a dominant profession; in exchange, the aspiring profession must accommodate the demands of that sponsor. The result is often a limitation in scope of practice, subordination of its practitioners and some degree of medicalization. Indeed, such limitation has been seen in England, Australia and the United States midwifery integration processes. During the legislation process, however, Ontario midwives received support largely through government groups directly, which is often a successful strategy for aspiring professions that are largely dominated by women. (28:176)

It is certainly plausible that as Ontario midwifery practices sought privileges and integration into their community hospitals, they conceded some areas of their scope in order to “get in the door” and to begin to build good relationships and trust. They may have assumed that they could seek expansion later, once they were well-established in the hospital system and many practices have, in fact, achieved this. (personal communication- Vicki Van Wagner, March 2008) Other practices, however, continue to face obstacles in their efforts to achieve full-scope. This may simply be due to a resistance to change on the part of the hospital or lack of understanding

of midwifery scope of practice, or perhaps there is a degree of underlying professional territorialism. (19:17,30) Hospitals and other care-providers report some medico-legal concerns about areas that overlap with midwifery care, such as oxytocin induction under the order of a physician for a labour that is managed by, and under the primary responsibility of, a midwife. (19:34) Otherwise, it is difficult to assess the reasons why practices might not be successfully achieving scope expansion when they wish to do so. Conversely, there are likely situations where the hospital prefers that its midwives practice to the full extent of their scope, but the midwives prefer a limited scope based on their own workload considerations or philosophy of *normal*. This is discussed further, under “Implications for Practicing Midwives”.

The apparent difficulties in achieving full scope well after hospital integration might underscore the importance of newly formed practice groups in the province to insist on working within their full scope when initiating negotiations for hospital privileges.

Implications for midwifery in Ontario

Scope of practice in the future

While some midwives are currently working to achieve the scope of practice originally mandated by the CMO, others have begun advocating for expansion. The CMO and AOM are currently lobbying for a number of items to be added to the existing scope of midwifery practice in the province. (34, 35:4) Perhaps the most notable is the request for an amendment to the drug and laboratory regulations. Midwives in Ontario cannot, for example, prescribe antibiotics for common conditions of pregnancy, including urinary tract infections (bacteriuria) or vaginal/rectal Group B Streptococcus (GBS) colonization. Midwives can, however, collect the

samples and request laboratory analysis, but if positive results are returned, the midwife must refer the client to her family or other physician for a prescription. This usually means an additional appointment for the client and the temporary introduction of a second caregiver.

(19:133) The CMO is currently seeking independent authorization for antibiotics to enhance primary maternity care. (35:4) They have also made this request for greater control in light of the extended length of time that regulation amendments have taken in the past, noting that “new medications and procedures are a constant in the delivery of health care in today’s environment”. (36:3) Interestingly, some American certified nurse midwives (CNMs) require a master’s degree before they are authorized to prescribe drugs, while New York is the only state that allows full prescriptive authority to direct-entry midwives (DEMs). (37:138,141)

The CMO has also noted that fentanyl, a narcotic analgesic, is not a listed substance for midwives and they have made their concerns known to the Health Canada Office of Controlled Substances. Fentanyl is commonly prescribed by physicians for pain relief in labour, making it readily available in the hospital setting and to midwives, while other drugs are not so easily accessible. The CMO has requested that Health Canada reconsider and revise the list accordingly. (38)

Other pending additions to scope of practice include the ability for Ontario midwives to perform neonatal intubation when necessary; this is not currently an authorized act. The CMO, through their participation in the Multidisciplinary Collaborative Primary Maternity Care Project (MCP²), has brought this issue to the attention of the Health Professions Regulatory Advisory Council (HPRAC), an organization that advises the Ministry of Health and Long-Term Care on policies relating to the regulated health professions in the province. (39, 36:2) In their letter to

the HPRAC, the CMO noted that the presence of a caregiver capable of performing intubation at every birth is considered a national standard for primary maternity care providers in Canada.

They also note that Ontario is the only province with regulated midwives that does not include neonatal intubation as an authorized act, and have requested an amendment to the *Midwifery Act, 1991*. (36:2) This skill has some potential to improve the quality of care that midwives can provide, particularly at homebirths, where access to appropriately trained Emergency Medical Services (EMS) might be difficult or delayed.

In this same submission to the HPRAC, the CMO has also requested clarification on the performance of such procedures as application of a fetal scalp clip, performing fetal scalp blood pH sampling and manual removal of the placenta. In addition, they have requested the option of exploring “extended class” options for midwives working in communities with limited access to additional services. In such areas of the province, midwives could, for example, provide care beyond six weeks postpartum or repair third and fourth degree perineal tears. (36:3)

While such an extension of scope might not be relevant to all midwives practicing in Ontario, especially those in large, urban centres, incorporation of any required training into the existing Midwifery Education Program might not be necessary. Instead, midwives could participate in additional training components to gain the appropriate skills for extended practice. This approach, however, may introduce a degree of confusion for consumers who may not be able to distinguish between different “categories” of midwives if there is significant expansion for rural midwives with only minimal change for more urban midwives. It also has the potential of creating a hierarchy within the profession that may further complicate roles and professional relationships. (37:146)

While many midwives may favour the idea of expanding their scope of practice, any changes should consider the implications for clients and how each added component adheres to the Ontario model of practice and the complex idea of midwives as the “guardians of normal”. One British study of midwifery ventouse practitioners (MVPs) showed that midwives can develop skills that are not generally considered normal, but still remain true to the midwifery philosophy of care. Although the MVPs could perform vacuum deliveries, they worked within much tighter guidelines than did obstetricians, thus enabling them to bring a birth back to normal as much as possible. (40:166) It was also found that these midwives had significantly increased their skill in assessing fetal position and station and they believed they were able to allow the woman to feel that she had delivered the baby herself, without a significant intervention. (40:168) The midwives were also very clear about their reluctance to use the term MVP as they did not feel they were special or should stand out from their colleagues, thus minimizing the risk of development of a hierarchy. (40:171)

Clearly, changes to the existing scope of midwifery practice in Ontario should be carefully implemented: globally and individually. Consideration should also be given to what training or education system is required. In addition to the effects on midwifery clients, the expansion of scope of practice should also consider the implications for midwives themselves.

Implications for practicing midwives

The current scope of practice varies greatly between midwifery practice groups in the province and as compared to the IMDCTC. The implications of this variation affect both practice and policy issues. Perhaps most obvious and salient are the issues of workload and salary; Ontario midwives are paid an experience-based fee for each course of care by the provincial

health care system. This fee does not account for variations in the care requirements for each course. (41) As such, there may be a perceived inequality between midwives who work within a full-scope framework and those who do not. The management of epidural analgesia illustrates this point well: in some practices, epidurals require a transfer of care to an obstetrician. Nurses become involved to manage the equipment, complete all charting requirements and assess the progress of labour, reporting to the on-call obstetrician. Additional health care costs may be associated here, with a much larger team now involved in the labour and birth. The birth is conducted by the obstetrician, although in some cases the midwife may be allowed a “courtesy catch”. When care is transferred, the midwife takes on a role of supportive care or if she has been awake for an extended period she might leave and rest herself, returning later for the delivery and initial care of the newborn. In contrast, a midwife working within a full-scope model will maintain the responsibility for managing the epidural and conducting the birth, consulting with obstetrics as needed. She is not afforded the opportunity to rest as she must continue to monitor and manage the woman’s labour. This demonstrates a potential inconsistency in workload and some might argue that midwives working in a full-scope practice should receive appropriate, additional compensation for these births. The midwife in the latter situation, however, is also more likely to be relieved by a practice partner sooner, which illustrates the importance of creating models of practice that ensure appropriate relief of practice partners and maintenance of safe and competent care. (According the CMO philosophy of continuity of care, the woman should have already met this “relief” midwife. (42)) It might be interesting to assess the perceptions and responses of clients in these situations to determine if either approach is more satisfactory or preferred by consumers and how it should affect compensation, if at all.

The recommendation that the IMDCTC guide hospital policies on the scope of midwifery practice has been discussed, along with the CMO's support for full-scope practice by all midwives in Ontario. Another consideration is that some midwives may not want to work in such a framework, even when the hospital wishes them to do so. There are several possible reasons for preferring limited scope, including decreased workload and a more balanced lifestyle, a desire to maintain a slightly different philosophy of birth as *normal*, and possibly an appreciation that continuity of care includes, and is sustained by, the provision of supportive care. The importance of a midwife's preference for scope of practice poses an important question of whether limited scope should be an option. As mentioned earlier, the client's right to the scope mandated by the CMO and the additional use of nursing and medical resources further complicates the debate and presents an interesting and extensive discussion that is beyond the intent of this paper.

With respect to the possibility of scope expansion in the future, the International Confederation of Midwives (ICM) has conducted a global, five-year study (including Canada) that developed a list of essential and additional competencies for midwives. ICM member organizations (which included midwives and students) and regulatory representatives took part in the study and assessed a number of skills as essential, additional or inappropriate to midwifery practice. The clinical skills that were studied included, among others, cervical cytology, external cephalic version (ECV) for breech presentation, performing pelvimetry and episiotomy, management of prolapsed cord, malpresentation and shoulder dystocia, manual removal of placenta and vacuum- or forceps-assisted delivery. (43) It is important to note that most of these skills are currently included in Ontario midwives training and scope, with the exception of instrumental delivery. Such studies, both international and interprovincial, can provide valuable

insight to what additional skills or competencies should or should not be incorporated into the Ontario model of practice.

Implications for students

Scope of practice has significant implications for Ontario midwifery students, as well. This becomes most prominent when students enter the clinical portion of the Midwifery Education Program (MEP) and are directly exposed to and affected by the scope practiced by the particular midwifery group with which they are placed. Perhaps most significant is the effect of scope on students in their final year (completing Midwifery Care III, IV and Clerkship), who act as one of two midwives at each birth by the time they are ready to graduate.

As clinical placements are assigned based on a lottery system, students do not have very much control on where they are placed and whether that placement reflects the scope within which they ultimately want to practice. That is, a student might highly value a full-scope practice model, but be placed in a limited-scope practice. In such an environment, she does not have the opportunity to learn those restricted skills, such as management of oxytocin augmentation or induction, or epidural analgesia. Moreover, if the midwives are generally not permitted “courtesy catches”, the student might also experience great difficulty in achieving the number of births she requires to graduate, especially when working at a teaching hospital where medical students and residents also need deliveries. Where “courtesy catches” are limited, the student may have to take on more clients or more births to achieve her required numbers, which can create an imbalance in workload and place her at an academic disadvantage. Students must also complete coursework, exams and papers while in clinical placement.

One Australian study assessed how medical and midwifery students viewed their respective roles on the labour ward and found that the framework within which they worked to be competitive rather than collaborative and had the potential to negatively influence future working relationships. (44:407) This is not conducive to the relationship that is required to appropriately support necessary consultations and transfers of care and has the potential to create a long-term, negative mindset in the student. The study also showed that a collaborative teaching approach could minimize diverging attitudes of medical and midwifery students, and might be helpful in finding useful solutions for those midwifery students placed at limited-scope practices and in teaching hospitals where many deliveries might be conducted by other students. (44:407)

It is also feasible that students placed in a limited-scope practice, especially in their final year, might be at a disadvantage when seeking employment after graduation and could be of great concern to students during their clinical placements. The same student who wanted to work in a full-scope practice will have to learn those skills on the job and will likely require some additional mentorship or supervision until she has developed them sufficiently. While it is unlikely that this is currently occurring, practice groups might preferentially hire a new graduate who has already developed this skill set to minimize their additional workload in such training.

Finally, the scope of practice defined by the CMO and practiced by midwives throughout the province may affect students as they transition into the clinical placement setting. Much of the theoretical training in the early years of the MEP focuses on birth as a normal, physiological process and there is much emphasis on attending to the emotional, cultural and spiritual needs of a diverse population of pregnant women. The student's understanding of *normal*, in particular, and midwifery practice, in general, can experience a great shift at the beginning of her clinical

placement, a phenomenon referred to as the “theory-practice gap”. (45:71) Students might suddenly find that their initial beliefs and values about midwifery are not completely congruent with what the CMO names as *normal birth* and what they are seeing in practice; some significant adjustment might be necessary as they embark on their clinical training. For example, a junior student might not believe that induction of labour is within the range of *normal birth* and that midwives should not manage such care. This same student could later be placed in a full-scope practice, where she is expected to learn this skill and she must then re-assess her values and move forward accordingly, either accepting the CMO indications or not.

While scope of practice can affect students on a very practical level, especially with respect to placement in a full-scope or limited-scope placement, it can also affect a student’s core beliefs and values of midwifery care on a much more philosophical level. This may point to the importance of feedback and discussion of these issues not only with course tutors but also with midwifery preceptors.

Conclusion

As has been discussed throughout this paper, the importance of maintaining birth as a normal, physiological event in a woman’s life is a fundamental aspect of midwifery care. It is foundational to the development and understanding of the scope of midwifery practice. Midwives working in Ontario have worked hard to create a definition of normal that is reflected in the CMO Indications for Mandatory Discussion, Consultation and Transfer of Care, the primary document that outlines scope of practice. The many guidelines and standards held by the CMO were developed with great foresight and provide a great degree of flexibility and autonomy for the profession.

Ontario midwives have proven their ability to bring about political change, most obviously through successful lobbying for legislation. This same political fire will be required not only for maintaining existing scope, locally and provincially, but also for any future expansion or alteration. The way that midwives choose (or not) to practice individually plays an important role in the way that midwifery, as a profession, is regulated and practiced. (46:27) The way that midwives teach the next generation also paves the road ahead for how midwifery will be practiced in the future. Finally, by maintaining a strong sense of the philosophy of care, midwives can protect the midwife-client relationship and allow women to expect a normal birth (rather than treating it as an “added bonus”), while working well within their scope of practice and model of care.

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