August 14, 2008

Ms. Anne Schiefer
Health Professions Regulatory Advisory Council
55 St. Clair Avenue West.
Suite 806, Box 18
Toronto, Ontario

Dear Ms. Schiefer,

Thank-you for the opportunity to respond to the College of Midwives of Ontario's (CMO) proposed changes to the Midwifery Act and the related regulations. The Midwifery Education Program Consortium supports the initiative of the Health Professions Regulatory Advisory Council and the College of Midwives. This provides important and exciting opportunities for the ongoing development of the profession of midwifery and its role in meeting maternity care needs across the province.

We are responding as the Directors of the Midwifery Education Program Consortium, representing Laurentian, McMaster and Ryerson Universities. We will comment on the educational implications for the proposed changes to the Midwifery Act and regulations and our capacity to meet these.

Sincerely,

Susan James Eileen Hutton Vicki Van Wagner

Curriculum readiness for changes in the scope of practice

The Midwifery Education Program was designed to prepare midwives for professional practice in the province of Ontario by providing academic and clinical education opportunities to ensure that the CMO core competencies are attained at an entry to practice level by the time of graduation. Since its introduction in fall 1993, the curriculum has been revised to keep current with the directions of the College and evidence based practice recommendations. Internationally, the scope of midwifery practice is broader than the current Ontario scope and we welcome the opportunity to teach to a broader scope as described in the International Definition of the Midwife (ICM) and reflected in the CMO recommendations to HPRAC. We support the removal of the terms "spontaneous" and "normal." This change allows us to continue our emphasis on normal as an important concept in midwifery education and practice, while at the same time, clarify that the role of the midwife must include practices that are not well understood as falling within the realm of "normal" such as induction or augmentation of labour.

The program is currently well placed to adapt its curriculum as we are engaging in an extensive process of curriculum revision after expansion of the program was announced in September 2007. We can also comment on the need to make these changes to the midwifery scope in order for the profession to provide the safest and most effective care to the women and babies under the care of midwives. Adoption of the CMO's proposed changes would support best practice and therefore optimal settings for the education of midwives, by clarifying and facilitating full scope and evidence based practice and therefore providing more consistent experience for students in their clinical placements.

Clarifications in the scope of midwifery practice

The majority of the changes in the routine scope of practice proposed by the CMO are clarifications of areas of scope that are well covered by the current MEP curriculum. These activities are part of normal practice for many midwives in the province and have been part of the curriculum since its inception. These areas include induction and augmentation of labour both by artificial rupture of membranes and by pharmacologic means; providing care and monitoring when women have epidural analgesia; emergency management of postpartum hemorrhage including manual removal of the placenta in the absence of medical help. All of these areas are covered in our curriculum, through academic learning in problem based tutorials; via hands on workshops; interdisciplinary lectures and in clinical placements.

Midwifery clinical placements consist of 5 terms with midwife preceptors working full time in clinics, homes and hospital. Third year placements (previously one term and now two terms) include nurses, obstetricians, pediatricians and/or respiratory therapists. Key objectives for these placements include providing care for women and babies whose care involves interventions and opportunities for interdisciplinary practice. Some of these areas, such as induction, augmentation and epidural analgesia have been strengthened within the MEP curriculum over the past five years, in recognition that students who work in areas where midwives' practice is restricted may need additional teaching provided by the program. The MEP asks all midwifery clinical teachers to ensure students have adequate exposure to these areas even if the local hospital requires transfer of care to medicine and nursing when midwifery clients require these interventions. The midwifery student continues as a learner involved with the woman's care, taught after transfer by other members of the health care team as well as her midwife preceptor.

Emergency Situations

All students in placements are required to certify in Neonatal Resuscitation annually. The accepted certification program has recently been updated to include neonatal umbilical vein catheterization and laryngeal mask airway placement. Intubation is already a component of the course. This requirement for yearly certification is part of maintaining registration with the CMO for all practicing midwives and it is worth noting that this requirement is more rigorous than the standard for most professionals, which is every two years. Emergency neonatal skills such as this are not anticipated to be used in settings where there is access to either respiratory technologists or pediatric specialists within a reasonable time frame. However it makes sense to allow those midwives who are working in settings where they may be the most responsible care provider present in an emergency or the most skilled team member to develop and maintain these skills.

Emergency skills such as manual removal of the placenta, vacuum delivery, cesarean section assist or repair of 3rd or 4th degree tears are potentially very important to midwives working in rural and remote areas. While not all midwives will want to work in a setting where these competencies are routinely required, we believe that all students ought to be introduced to the basics to provide a foundation for practice situations where these are required in order to provide the safest care to women. In any emergency situation, the most prudent practice decisions are based on having the most skilled person provide the care at the right time and place and ideally as determined by an interdisciplinary team. These competencies are not included in this proposal to create barriers to interdisciplinary practice; this is proposed as a strategy to facilitate interdisciplinary practice.

As the possibility of including new skills to the midwifery scope has been discussed in many forums over the past five years, many obstetric and pediatric specialists have

offered to participate in the education that will be required, as they see that educating midwives in these skills is important for access to safe care, particularly in under-serviced settings. As educators we do not see any barriers to providing appropriate learning opportunities. The curriculum revisions include the SOGC ALARM course in the third year of the program where these competencies are taught and assessed. The ongoing maintenance of these competencies will need to be addressed in strategies involving all of the midwifery stakeholder groups. The current Emergency Skills and Neonatal Resuscitation recertification requirements provides us with good evidence that midwives can and will follow best practices in continuing emergency skills education.

Communicating a Diagnosis

As educators, we are also very comfortable with midwifery student's preparation in regard to the CMO's suggestion that midwives have the communication of a diagnosis included in their scope. There is no question that differential diagnosis is taught throughout the program, and is a major focus of the problem-based tutorials which accompany clinical placements beginning in the 2nd year of the program. The curriculum change that will be required is a reframing to emphasize the midwife's responsibility to communicate the diagnosis. The first placement course covers common pregnancy screening, diagnosis and treatment of conditions such as nausea and vomiting of pregnancy; urinary tract infections; vaginal infections; gestational diabetes; breast infections; newborn thrush and breast-feeding problems. The third year curriculum includes extensive coverage of common variations of normal including differential diagnosis and treatment of first trimester bleeding; labour dystocia; prelabour rupture of membranes; postpartum maternal infections; newborns who are slow to gain; the roles and scopes of other health professionals and appropriate collaboration, consultation and referral. The senior year courses cover situations in which midwives may remain primary care givers in situations which require consultation with obstetrics or pediatrics. Examples of midwifery differential diagnosis include preterm labour, suspected IUGR and failure to thrive in the newborn. Differential diagnosis is taught in scenarios about complex cases involving several layers of differential diagnosis as well as interaction with and referral to a broad range of health care providers. Throughout these courses students are in full time clinical placements where differential diagnosis is part of day to day midwifery practice and students get extensive experience in decision making and care planning.

Pharmacology – prescription and categories of drugs

Our program includes a mandatory course 2nd year course in Pharmacology which covers not only broad principles related to pharmacokinetics and the particular drugs which midwives can currently prescribe and administer but also common drugs used in obstetric situations, including antibiotics, anti-hypertensives, anti-seizure medications,

tocolytic agents and oral contraceptives. The use of the wide range of drugs used in obstetrics is reviewed and reinforced in the placement tutorials.

As educators and academics, our goal is to teach best practice according to the available evidence and national guidelines. We strongly support changes to allow midwives classes of drugs and other changes which will allow a flexible framework that facilitates adaptation as midwives' practices evolve with the incorporation of new evidence and with the development of national midwifery and inter-professional guidelines for best practice. We are aware through our interaction with practices around the province where students are placed, that the current system has created many problems. A very common example is when local physicians and health care institutions expect midwives to independently follow national guidelines such as those developed by the Society of Obstetricians and Gynecologists of Canada for Group B streptococcus prophylaxis and management of postpartum hemorrhage. This is not an unreasonable expectation. However, midwives are not able to prescribe these drugs. For many midwives and other health care providers it has been hard to understand why the regulatory framework stood in the way of evidence-based practice. In many communities this situation has led to tensions in the relationships among healthcare providers and at times to less than optimal practices. We are aware that in some cases the lack of access to treatment for GBS antibiotics has led some midwives to restrict choice of birth place for women who screen positive, which has meant that many women who choose home birth decide not to screen for GBS colonization. This reflects practice driven by lack of access to recommended treatments rather than a fully informed choice based on access to best practice approaches.

Laboratory and other investigations

The discussion above applies as well to the expansion of laboratory and other investigations such as ultrasound. The mandatory life sciences course provides a basis for the understanding of laboratory tests relevant to maternity care. Appropriate use and interpretation of laboratory tests and other investigations are included in the case studies that form the basis of the placement course tutorials.

Ambulance Act

The amendments to the Ambulance Act proposed by the CMO are needed to bring the Act and its regulations back to its intended relationship to midwifery practice which was negotiated as part of the original regulation of midwifery in 1993. It is our understanding that the Act was amended, making it unclear that midwives have the authority to direct ambulance transport, when safe and appropriate, to a hospital where the midwives have privileges and where obstetrical back-up has been arranged. Midwifery students are taught about interaction and collaboration with EMS professionals, about transfer from out of hospital settings and Level 1 and II hospitals in

emergent and non-emergent situations and appropriate reporting to and with interaction with the referral centres.

Well Woman – Well Baby Care

The CMO proposal extends the role that midwives could play in under-serviced communities allowing health care services to utilize midwives in well woman and well baby care. The midwifery education program teaches well woman and well baby care within the context of the current period of practice from early pregnancy to 6 weeks postpartum and involves nurse practitioners, public health professionals, pediatricians and neonatologists in the education of student midwives in these areas. The curriculum also addresses well women and well baby care issues that are relevant beyond these boundaries as this information is critical to adequate counseling of clients to prepare for later healthcare needs. For example, to reach goals of exclusive breastfeeding for 6 months and continued breastfeeding for two years and beyond, anticipatory support during pregnancy and the early weeks of breastfeeding is demonstrated to result in longer duration rates of breastfeeding. If the scope was extended the program could be readily adapted to cover an extended time frame and role, or alternately the competencies could be covered in a continuing education format.

Hospital Maternity Care Governance Roles

As educators we strongly support the CMO's proposal to allow midwives to participate in hospital credentialing and decision making committees, such as Medical Advisory or Professional Advisory Committees. We believe that a commitment to inter-professional collaboration means that midwives must be included in decision making at all levels of the maternity care system. At the outset of Midwifery Regulation, this degree of participation was an objective. At this time we acknowledge that this is essential to address the restrictions that midwives currently face within their current scope and which act as barriers to midwives making a full contribution to addressing the need for maternity care providers. It is also important to providing effective and efficient care to midwifery clients. We currently expect that students in placements will participate in professional activities like hospital or LHIN committees and education sessions. Governance competencies are introduced in the latter years of the curriculum and will be emphasized even more strongly in the revised curriculum. We are also now in a position to be able to offer an option of administrative and professional organization placements to students in the third year.

While we have not addressed all the details included in the CMO proposal, we hope that we have demonstrated a readiness and commitment to support the educational needs of a change in the scope of practice. We are building a strong team of midwifery educators and are developing interdisciplinary partnerships with other professional groups within and external to our university settings. The curriculum revisions

and other initiatives related to the recent expansion of the program have set up an opportunity to be well positioned to respond to the CMO proposal.

We would be happy to provide further consultation from the perspective of the Consortium or from any of the three sites if this would be helpful.

Director, Laurentian University Midwifery Program

Eileen Hutton

Director, McMaster University Midwifery Program

Vicki Van Wagner

Director, Ryerson University Midwifery Program