The Ontario Hospital Association

The Ontario Hospital Association (OHA) is the voice of Ontario’s public hospitals. Founded in 1924, the OHA uses advocacy, education and partnerships to build a strong, innovative and sustainable health care system for all Ontarians.

Disclaimer

The Resource Manual for Sustaining Quality Midwifery Services in Hospitals is intended for use by all hospitals. No part of this Resource Manual is intended as, or should it be considered, legal advice.

Online Access

The Resource Manual is available free for download to OHA members at www.oha.com under “Knowledge Centre – Library – Manuals”.

The Resource Manual for Sustaining Quality Midwifery Services in Hospitals was developed by the Ontario Hospital Association, the College of Midwives of Ontario and the Association of Ontario Midwives.
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Executive Summary

In 1994, following the regulation of the midwifery profession, the Ontario Hospital Association published the Integration of Midwifery Services into Hospitals Handbook, which identified the major issues hospitals would need to examine as they considered the integration of midwifery services into hospital practice.

It has been 15 years since the original publication of the Handbook and an updated version is needed. The integration of midwives into hospitals as primary care providers is now an established reality. Midwives have obtained privileges in over three quarters of Ontario hospitals with obstetric units. Approximately 80% of midwifery clients choose to give birth in a hospital. In some cases, hospitals have formed midwifery departments and midwives participate on medical advisory committees and professional staff executive committees. Just as midwives have become integral in many hospital maternity care units, hospital integration has become increasingly important to the practice of midwifery in Ontario.

Still, hospitals regularly raise questions and issues regarding midwifery that stem from a lack of information about the profession. This resource is intended to provide the necessary information required to assist hospitals and practitioners in planning and decision-making regarding midwifery services.

Since midwives started practicing in hospitals 15 years ago, the practice has evolved, interprofessional relationships have formed, and hospital organizational structures and management have adapted to these changes. This evolution provides a wealth of information and insight that is useful for consideration regarding midwifery integration into hospitals.

The Ontario Hospital Association supports the integration of midwives into the services provided by Ontario hospitals, and recognizes midwifery as a reliable and effective means of providing high-quality maternal and newborn services. Hospitals are encouraged to consider adding midwifery to their service programs, and to incorporate best practices to sustain safe, quality midwifery services.
How To Use This Resource Manual

The Resource Manual for Sustaining Quality Midwifery Services in Hospitals has been developed for use by hospital leadership, physicians and health professional staff in response to a number of requests for resources regarding the ongoing integration of midwifery in hospitals.

Developed by the Ontario Hospital Association (OHA), the Association of Ontario Midwives (AOM), and the College of Midwives of Ontario (CMO), in consultation with other stakeholders, this Resource Manual provides information, resources and tools drawn from current leading practices as well as guidelines and templates for integrating midwives into the hospital setting.

This Resource Manual serves the following purposes:

1. To assist hospital leaders who are seeking to integrate midwives into their hospital for the first time.
2. To provide resources for hospitals that have already established midwifery services.
3. To provide examples of lessons learned in midwifery integration over the past 15 years.
4. To help foster excellent interprofessional relationships in hospital-based maternity care.

The Resource Manual will enable leaders to identify areas where they are doing well with midwifery integration, and where there may be room for improvement. As always, a hospital must consider its own unique characteristics and culture in the provision of maternal and newborn services when addressing these issues.

Although this Resource Manual can be read from cover to cover, it has been organized so that each section can also stand on its own to assist hospitals with various stages of the integration process. The Resource Manual is organized into three sections:

Primer – This section provides readers with a comprehensive understanding of the midwifery profession and how it currently fits in the Ontario health care system.

Implementation Guide – This practical guide outlines in a step-by-step process, what hospitals and midwives can do to facilitate successful integration in a hospital environment.

Appendices – A number of helpful tools and resources have been included in this Resource Manual to assist hospital leaders and maternity care providers in establishing and sustaining quality midwifery services in hospitals.

Icon Legend

- Identifies the key messages of the chapter.
- Identifies leading practices being used to integrate or maintain midwifery services in the hospital.
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1.1 The Midwifery Act

The Midwifery Act, 1991 describes the practice of midwifery as the assessment and monitoring of women during pregnancy, labour and the postpartum period and of their newborn babies (see Appendix H2: Midwifery Act, 1991). It includes the provision of care during normal pregnancy and labour, conducting spontaneous normal vaginal deliveries, and the provision of care in the postpartum period.

It also states that in the course of engaging in the practice of midwifery, a member is authorized to perform the following:

- Manage labour and conduct spontaneous normal vaginal deliveries.
- Perform episiotomies and amniotomies and repair episiotomies and lacerations not involving the anus, anal sphincter, rectum, urethra and periurethral area.
- Administer, by injection or inhalation, a substance designated in the regulations.
- Insert an instrument, hand or finger beyond the labia majora during pregnancy, labour and the postpartum period.
- Take blood samples from newborns by skin pricking, or from women, using veins or by skin pricking.
- Insert urinary catheters.
- Prescribe drugs designated in the regulations.

Changes to the Midwifery Scope of Practice

In December 2009, the Midwifery Act was amended by the Regulated Health Professions Statute Law Amendment Act (Bill 179). As of July 31, 2010, these sections have not yet been proclaimed into force.

The primary additions to the midwifery scope of practice are:

- Communicating a diagnosis identifying as the cause of a woman’s or newborn’s symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a member is authorized to order or perform on a woman or a newborn during normal pregnancy, labour and delivery and for up to six weeks postpartum.
- Taking blood samples from newborns by skin pricking or from persons from veins or by skin pricking (this change is to allow midwives to take blood samples from fathers or donors).
- Intubation beyond the larynx of a newborn (this change is to allow midwives the authority to intubate a newborn in an emergency situation where they are the most skilled practitioner at the scene).

For more information, visit www.e-laws.gov.on.ca.
“Allowing our health care professionals to make better use of their skills and talents will offer many more choices to patients and increase access to care. This legislation is a great step forward in delivering sustainable health care to all Ontarians.”

- Deb Matthews, Ontario Minister of Health and Long-Term Care

1.2 Requirements
For Becoming A Midwife

In order to become a registered midwife in Ontario, an applicant must have a baccalaureate degree in Health Sciences (Midwifery) or qualifications equivalent to the baccalaureate degree.

Continuing Competency Requirements

The CMO ensures that members maintain competence through several mechanisms. Members are required, through the annual renewal of their registration, to maintain current certification in obstetrical emergency skills, neonatal resuscitation and cardiopulmonary resuscitation.

The CMO’s Quality Assurance Program (QAP) requires annual reporting on a member’s participation in a number of activities, including (but not limited to):

- peer case reviews
- continuing education
- client satisfaction evaluations

Entry to Practice Requirements

All applicants must have current clinical experience consisting of attendance at 60 births, 40 of these as the primary midwife, and experience at both hospital and home births. Applicants must show proof of professional liability insurance and current certification in cardiopulmonary resuscitation, neonatal resuscitation and obstetrical emergency skills.

New Registrants’ Requirements

Every newly registered midwife is required to work in an established practice and attend 30 births as the primary care provider with an experienced midwife for their first year of registration. This policy serves to provide newly registered midwives with support and mentoring as they enter the profession.

The CMO requires that all midwives certify annually in neonatal resuscitation and bi-annually in obstetrical emergency skills and cardiopulmonary resuscitation.

The CMO also annually selects members and their practices at random to undergo a complete clinical and administrative audit of their midwifery practice. For more information, visit the CMO’s website at www.cmo.on.ca.

1.3 Midwifery Education
Ontario Universities and Clinical Placements

A consortium of three universities in Ontario (McMaster University in Hamilton, Laurentian University in Sudbury, and Ryerson University in Toronto) provides the Midwifery Education Program (MEP), which is a four-year baccalaureate program in midwifery.
Students are based at one of the three universities that share a common curriculum, including clinical placements. Clinical placements comprise 50% of the curriculum and occur with midwifery practices and in interprofessional settings across the province. Issues of risk management and client safety are also part of the curriculum and are regularly addressed in a number of different courses at each level of the program. The MEP is working to ensure collaborative educational opportunities exist for midwives with physicians, nurses and other maternity care professionals.

For more information, visit the MEP websites: http://www.ryerson.ca/midwife/, http://fhs.mcmaster.ca/midwifery/, http://www.midwifery.laurentian.ca.

1.4 Midwives From Other Provinces

Under the Agreement on Internal Trade (AIT), certified professionals are able to move freely to work where opportunities exist or where they choose to live in Canada. The Ontario Labour Mobility Act, 2009 stipulates that professionals who are already registered in another province or territory are entitled to be registered in Ontario without having to complete additional material training, experience, examinations or assessments.

The set of knowledge, skills and abilities required to practice as a midwife in the regulated jurisdictions of Canada were established in 2005 by the Canadian Midwifery Regulators Consortium (CMRC) through the Canadian Competencies for Midwives (see Appendix G2: Canadian Competencies for Midwives). The continued use of these competencies by other Canadian regulators, and the implementation of the competencies by provinces who are seeking regulation, means that the CMO can expect that midwives coming to Ontario from out-of-province are equipped to provide the same level of safe, effective care expected of midwives who are educated in Ontario.

For more information, visit the Ontario Immigration’s website at http://www.ontarioimmigration.ca/en/working/OI_HOW_WORK_MIDWIFE_CM.html.

1.5 The Growing Demand For Midwifery Services

According to the Ontario Midwifery Program (OMP), by the end of 2008, midwives were attending nearly 10% of Ontario births; however, they were able to meet only 65% of the demand for their services.
Figure 1: Demand for Midwifery Services (1999-2007)

Source: Ontario Midwifery Program

See Appendix J2: Maternity Care Databases for an overview of the databases used to collect maternity care information for the purposes of administration, quality assurance, public accountability and research.
1.6 How Midwifery Services Are Funded

A group practice framework supports the model of midwifery, with its focus on continuity of care and 24-hour on-call availability (see Appendix H1: Association of Ontario Midwives and the College Of Midwives of Ontario’s Consensus Statement on the Model of Care for Midwifery in Ontario).

The Ministry of Health and Long-Term Care (MOHLTC) supports a group practice model by funding midwives through practices, rather than individually. Midwifery practice groups receive funding through Transfer Payment Agencies (TPAs) in Ontario, which fund the practice groups according to a provincial agreement. TPAs include hospitals, community health centres and other primary health agencies (see Appendix H5: Midwifery Transfer Payment Agencies in Ontario).

The MOHLTC’s Ontario Midwifery Program compensates midwives with one fee following the completion of each course of care as outlined in Appendix H4: Schedule of Benefits (Midwifery Consultations). A course of care comprises midwifery services to a woman during pregnancy, labour and birth (including attendance by two midwives at either home or hospital) and to the mother and her newborn for up to six weeks afterwards. Midwives are also compensated for providing care to clients who are not covered by OHIP. For more information, please contact the Ontario Midwifery Program (see Appendix J3: Ontario Midwifery Organizations Contact List).

Summary Of Key Messages

- In Ontario, “midwife” refers to a member of the CMO who practices midwifery pursuant to the Midwifery Act and its regulations.

- In 2009, the scope of practice for midwives was expanded. Additions to the midwifery scope of practice include: an increased list of drugs and substances that may be prescribed and/or administered by midwives, intubation beyond the larynx of a newborn and taking blood samples from fathers/donors.

- All midwives in Ontario must have a baccalaureate degree in Health Sciences (Midwifery) or qualifications equivalent to the baccalaureate degree and have current clinical experience consisting of attendance at 60 births.

- The CMO requires that all midwives certify annually in neonatal resuscitation and bi-annually in obstetrical emergency skills and cardiopulmonary resuscitation.

- Midwives are funded through the MOHLTC and are compensated with one fee following the completion of each course of care which includes prenatal services through care of the mother and her newborn for up to six weeks after birth.
Chapter 2: The Midwifery Model of Practice
Chapter 2:
The Midwifery Model of Practice

2.1 Midwives As Primary Care Providers

Midwives offer a full course of maternity care (up to six weeks postpartum) to women with low-risk, healthy pregnancies and to healthy newborns. A woman does not need a referral from a physician to see a midwife. Midwives are, however, required to comply with the CMO’s Indications for Mandatory Discussion, Consultation and Transfer of Care (IMDCTC), which is a foundational midwifery guideline that establishes the clinical situations for which midwives are required to involve a physician in the care of a client (see Appendix G3: CMO Indications for Mandatory Discussion, Consultation and Transfer of Care).

2.2 Developing Group Midwifery Practices

Midwives work in practices that currently vary in size. Midwives in group practices share the care of clients and the on-call schedule. The midwifery group practice model of care was established so that midwifery clients receive 24-hour on-call support from their midwifery practice, while allowing midwives to maintain a reasonable work-life balance. There are currently 76 midwifery practices in Ontario (see Appendix J1: List of Midwifery Practices in Ontario).

Every midwifery client is cared for by a group of no more than four midwives, one of whom must be available 24 hours a day.

The MOHLTC supports the group practice model by funding midwives through their practice, rather than individually (see Appendix H1: AOM/CMO’s Consensus Statement on the Model of Care for Midwifery in Ontario and Section 1.6: How Midwifery Services are Funded).

2.3 The Three Tenets Of Midwifery Care

The midwifery model of care in Ontario has three primary tenets, which midwives are required to provide to all clients:
- choice of birthplace (home or hospital)
- informed choice
- continuity of care

Midwives are regulated to provide care in accordance with the standards of the CMO, which includes explicit reference to, and explanation of, three primary tenets. This consistent approach for all midwifery clients supports equitable primary maternity care services, as well as equitable access to care.
These elements of care are supported by evidence-based research and are promoted by national and international maternity care guidelines as best practice (e.g., the Public Health Agency of Canada’s The Family-Centred Maternity and Newborn Care: National Guidelines, 4th Edition).

Midwifery supports a non-interventionist approach to birth whenever possible, within strict safety guidelines (see Appendix G3: CMO Indications for Mandatory Discussion, Consultation and Transfer of Care, Appendix G4: Indications for Planned Place of Birth, Appendix G5: CMO Informed Choice Standard and Appendix G6: CMO Standard on Continuity of Care).

Choice of Birthplace

Offering women a choice of a home or a hospital birth is a requirement of the CMO and is an integral component of the midwifery model of care. No other regulated maternity care profession in Ontario offers this choice.

When Midwifery Clients Choose a Hospital Birth

Approximately 80% of midwifery clients choose a hospital birth. These women generally do not arrive at the hospital until they are in active labour. The midwife normally attends early labour at home and triages her client prior to hospital admission.

The midwife remains as the primary care provider for hospital births that progress normally and without complications. The CMO, through its IMDCTC, outlines the clinical situations where a midwife is required to transfer the care of her client to an obstetrician, usually due to increased risk of complication or an emergency situation that falls outside of the scope of midwifery practice (see Appendix G3: CMO Indications for Mandatory Discussion, Consultation and Transfer of Care).

Approximately 50% of midwifery clients are discharged from hospital within 24 hours of arriving.

Also see Section 4.2: When Midwifery Home Birth Clients are Transferred to Hospital or visit the CMO’s website at www.cmo.on.ca.

In some circumstances (usually prearranged), nurses perform the duties of the second birth attendant if the second midwife/attendant is not available (see Appendix F6: CMO Guidelines for the Second Birth Attendant).
Informed Choice

Informed choice is a regulated and integral part of the midwifery model and a standard of care of the CMO. Informed choice is an ongoing process that begins antenatally and continues throughout the course of care. Informed choice, as it is described by the CMO, may differ somewhat from the common understanding of the term “informed consent” (see Appendix G5: CMO Informed Choice Standard). Of particular note is the requirement that midwives support a client’s decision following an informed choice discussion. This is an integral component of the midwifery model which provides woman-centred care that respects the autonomy and decision-making authority of the client.

In recognition of the client as the primary decision-maker in her care, the CMO has prepared a guideline for when a client chooses care outside of midwifery standards of practice or against the midwife’s recommendations. This standard provides resources for midwives to support a woman’s decision after an informed choice discussion has taken place (see Appendix F4: CMO Guideline on When a Client Chooses Care Outside of Midwifery Standards of Practice).

All midwives are required by the CMO to provide informed choice to every client, which includes the midwife’s recommendation for the appropriate course of care.

According to the CMO standard, informed choice is a decision-making process between a midwife and her client in which the midwife ensures the client has access to appropriate information about the options available to her and then supports the client in selecting and following her preferred option.

The CMO requires midwives to provide each client with information that a reasonable person in the client’s position and circumstance would expect to receive to make choices or decisions, including:

- Potential benefits and risks of, and alternatives to, procedures, tests and medications
- Relevant research evidence
- Community standards and practice, including the midwife’s recommendation for the appropriate course of care

Continuity of Care Provider

All midwives are required by the CMO to provide continuity of care to all clients. According to the CMO, continuity is achieved when a relationship develops over time between a woman and her midwife, or a small group of midwives (see Appendix G6: CMO Standard on Continuity of Care). Research supports continuous care by a known care provider in pregnancy, labour and postpartum as a best practice.3, 4

Midwifery services are provided by the same small group of caregivers from the onset of care (ideally, at the onset of pregnancy), during all trimesters, and throughout labour, birth and the first six weeks postpartum.

A consistent philosophy of care and coordinated approach to clinical practice is facilitated by practice protocols, regular practice meetings and peer review. The CMO requires midwifery practices to have clinical care protocols to support continuity in their practice approach.
Summary Of Key Messages

- Midwives are primary care providers offering a full course of maternity care (up to six weeks postpartum) to women with low-risk, healthy pregnancies and to healthy newborns.

- Midwifery clients are cared for by a small group of no more than four midwives, one of whom must be available 24 hours a day.

- Midwives in Ontario are required to follow three primary tenets: choice of birthplace (home or hospital), informed choice, and continuity of care.

- All midwives are required by the CMO to provide informed choice to every client, which includes the midwife’s recommendation for the appropriate course of care.

- Two midwives, or one midwife and a qualified second birth attendant, are required by the CMO to attend every birth.

- Midwives offer women whose pregnancies meet established criteria the choice of delivering at home or in the hospital, and are required by the CMO to attend both home and hospital births every year to maintain competency in each setting.
Chapter 3: Scope Of Practice
Chapter 3: Scope Of Practice

Introduction

Midwives provide a full course of maternity care (antenatal, labour and delivery, and six weeks postpartum) to women with healthy, low-risk pregnancies. Midwifery practice is regulated and funded as a complete course of care (See Section 1.6: How Midwifery Services are Funded). All midwives are required by the CMO to provide the full course of midwifery care to all clients.

3.1 How Midwives Work With Physicians

The CMO outlines the clinical conditions for which midwives are required to consult with, or transfer care to, a physician (see Appendix G3: CMO Indications for Mandatory Discussion, Consultation and Transfer of Care (IMDCTC)). Ultimately, the responsibility to consult with a physician lies with the midwife.

Conducting a Care Discussion

The IMDCTC document states that midwives are responsible for initiating a discussion with, or providing information to, whomever the care is shared with (another midwife or a physician), in order to plan care appropriately.

Initiating a Consultation

It is the midwife’s responsibility to initiate a consultation. A consultation occurs when a midwife, in light of her professional knowledge of the client and in accordance with the standards of practice of the CMO, or where another opinion is requested by the client, requests the opinion of a physician competent to give advice in this field.

When initiating a consultation, the midwife can expect that:

- The consultation involves addressing the problem that led to the referral;
- An in-person assessment is done of the client; and,
- There is prompt communication of the findings and recommendations to both the client and the referring professional.
Following the assessment of the client by the physician(s), discussion can occur between the midwife and physician regarding future patient care.

There are three potential outcomes following the physician’s assessment:

- The midwife maintains overall responsibility for the client because the care required falls within her scope of practice.
- The physician may be involved in, and responsible for, a discrete area of the client’s care, with the midwife maintaining overall responsibility within her scope of practice. In this instance, areas of involvement in client care must be clearly agreed upon and documented by the midwife and the physician.
- The care required falls outside of the midwife’s scope of practice and care is transferred to the physician.

Transferring Primary Care to a Physician

When primary care is transferred from the midwife to a physician, the physician together with the client assumes full responsibility for subsequent decision-making. However, it is important to note that after primary care is transferred to a physician, the midwife may continue to provide supportive care within her scope of practice, in collaboration with the physician and the client. When the care required returns to the midwifery scope of practice, primary care is often transferred back to the midwife.

On overall responsibility and transfer of care, the CMO’s position is that one health professional has overall responsibility for a client at any one time and the client’s care should be co-ordinated by that health professional whose identity should be clearly known to all of those involved and documented in the records of the referring health professional and consultant. Responsibility could be transferred temporarily to another health professional, or be shared between health professionals according to the client’s best interests and optimal care; however, transfer or sharing of care should only occur after discussion and agreement among clients, referring health professionals, and consultants.

3.2 Medical Care That Falls Within The Midwifery Scope Of Practice

Epidurals and Induction/Augmentation of Labour

The midwifery scope of practice allows midwives to:

- Manage epidurals and induction/augmentation of labour
- Be the surgical first assist for caesarean sections

Managing the care of clients who have received an epidural or whose labour has been induced or augmented, is within the scope of midwifery practice,
given that the midwife has the required training and has engaged in appropriate consultation. The CMO has two documents that are specific to anaesthesia:

- Appendix E2: CMO Recommendation for Midwife Certification for Care of Women Receiving Epidural Pain Relief in Labour
- Appendix F5: CMO Guidelines to Antepartum Consultations for Clients of Midwives to Anaesthesia

These documents were developed with input from anaesthetists for the purposes of supporting continuity of caregiver for midwifery clients.

Once the appropriate consultation has taken place, if it is decided that care required can be provided within the midwife’s scope of practice then he/she may continue to care for the client, consistent with the concept of continuity of caregiver. The midwife would remain the primary care provider and because midwives are authorized to write orders for nursing staff, they may delegate some of the labour care to their nursing colleagues. As primary care providers and members of the maternity care team, it is expected that midwives receive the same support from nursing staff that a physician would receive.

### 3.3 Services Midwives Are Authorized To Order

**Prescribing and Administering Drugs**

Midwives are authorized to prescribe and administer drugs according to Appendix H3: Midwifery Act Designated Drugs Regulation. The drug regulation sets out the substances that a midwife may administer and prescribe on their own, as well as the substances that may be administered on the order of a physician.

**Midwives are authorized to order the following services:**
- Prescribing and administering drugs
- Lab work
- Ultrasounds

As of February 2010, the CMO’s Designated Drug Regulation was amended to expand the list of drugs and substances that may be prescribed and/or administered by midwives (see Appendix H3: Midwifery Act Designated Drugs Regulation). The amendments are intended to enhance public safety by ensuring that midwives have access to the appropriate medications and options available to them at all times, while also ensuring midwives’ use of those drugs is appropriate based on the midwife’s knowledge, skill, judgment and scope of practice.

The CMO will implement these amendments during 2010 and 2011 to ensure that members have received the appropriate education and training and to ensure the necessary regulations and standards are in place. The CMO’s plan includes a communication strategy to inform all stakeholders of the implementation of these changes.
Lab Work

Midwives are authorized to order lab tests as set out by the CMO (see Appendix F3: CMO Guideline on Laboratory Testing). The guideline sets out the tests that labs will be compensated for, through the Schedule of Benefits. Hospitals may decide to allow midwives to order tests that are performed and processed in the hospital.

For more information, visit the CMO’s website at www.cmo.on.ca.

Ultrasounds

Midwives are authorized to order prenatal diagnostic ultrasounds, as outlined in Appendix F2: CMO Guideline on Diagnostic Imaging.

For more information, visit the CMO’s website at www.cmo.on.ca.

3.4 The Importance Of Midwives Working To Their Full Scope

The Health Professions Regulatory Advisory Council (HPRAC), which advises the Minister of Health and Long-Term Care on issues regarding the self-regulation of health professions, recognizes the importance of midwives as specialists in low-risk maternity care. HPRAC’s 2009 Critical Links Report has recommended certain expansions to the midwifery scope of practice as well as to midwives’ prescribing authority to enable midwives to better fulfill their role.5

Some hospitals in Ontario place limits on things that midwives are able to do. For example, some hospitals require midwives to transfer the care of a client to a physician for indications and/or situations for which the CMO requires only a physician consultation. In these situations, the transfer of care is often referred to as ‘clinically unnecessary’ by the CMO, and may have implications for the quality of client care within the hospital.

The Family-Centred Maternal and Newborn Care National Guidelines outline the following as best practice:

“It is preferable to minimize the number of care providers, and to provide models of care that ensure that women will experience labour and give birth with at least one familiar professional at hand. Research has shown that women who had the continuity of supportive caregivers have considerably better outcomes in terms of reduced interventions, including reduced rates of lower Apgar scores, fewer intubations and resuscitations, fewer episiotomies, and increased levels of satisfaction.” 6

In 2007, the AOM surveyed Head Midwives asking them in which hospitals midwives were able to maintain care of their clients when administering oxytocin for induction and augmentation, and administering prostaglandin gel for cervical ripening. Both of these procedures are within the scope of midwifery practice as determined by the College of Midwives of Ontario, however, the survey showed that midwives were only enabled to maintain care for these procedures in half of the hospitals where they have privileges. In the other 50%, hospitals had a policy in place to transfer care to an obstetrician.
At the time of delivery, a midwife knows the clinical details of a client’s pregnancy, as well as her hopes and plans for the birth. It is important for hospitals to support the client’s needs by facilitating midwives to work to their full scope of practice, which can optimize health human resources and contribute to safe quality care. Clinically unnecessary transfers of care have the potential to lead to compromised quality of care. Hospitals are encouraged to review their policies and protocols regarding midwifery consultations with physicians to ensure the most efficient and effective use of resources.

In 2001, a Coroner’s jury recommended that all hospitals use the CMO’s IMDCTC to establish the scope of midwifery practice in their obstetrical units (see Appendix G3: CMO Indications for Mandatory Discussion, Consultation and Transfer of Care and Appendix E3: Coroner’s Jury Recommendations from Stalker Inquest). The IMDCTC facilitates consistency of midwifery care across the province and the appropriate use of midwife and physician providers.

**Summary Of Key Messages**

- Appendix G3: *CMO Indications for Mandatory Discussion, Consultation and Transfer of Care* outlines the clinical conditions for which midwives are required to consult with, or transfer care to, a physician usually due to increased risk of complication or an emergency situation that falls outside of the scope of midwifery care.

- The midwifery scope of practice includes: managing epidurals and induction/augmentation of labour, being the surgical first assist for cesarean sections, prescribing and administering drugs, and ordering lab work and ultrasounds.

- Allowing midwives to work to their full scope of practice and maintain care of clients reduces clinically unnecessary transfers of care and has implications for the quality of client care within a hospital.
Chapter 4: Midwives and Home Birth
Chapter 4: Midwives and Home Birth

4.1 When Women Choose Home Birth

The safety of home birth is demonstrated in recent research regarding the outcomes of midwife-attended births in Ontario and British Columbia (see Appendix I1: AOM Fact Sheet: Home Birth in Ontario – Information for Health Care Providers). Midwives have expertise in the continual screening and evaluation of a client’s health, as well as her prospects for safely delivering at home.

Two midwives, or one midwife and a qualified second birth attendant, are required by the CMO to attend every birth, in accordance with national standards on intrapartum care (see Appendix F6: CMO Guidelines for the Second Birth Attendant, Appendix C2: Attendance at Midwifery Births, Appendix C7: Nurse as Second Birth Attendant for Midwifery Delivery). The CMO outlines the equipment midwives must carry to home births, including oxygen and medications for managing postpartum hemorrhage (see Appendix I4: CMO Essential Equipment, Supplies and Medications). Also integral to the provision of quality care to women choosing a home birth is access to hospital services, should they become necessary.

All women who plan a home birth are made aware of the potential reasons for moving to a hospital through discussions with their midwife during their pregnancy.

According to the Midwifery Outcomes Report (MOR), approximately 20% of Ontario midwifery clients give birth at home, and the majority who plan a home birth end up having their baby at home.8

<table>
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<tr>
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<th>Number</th>
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<tr>
<td>2008/2009</td>
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<td>18.2%</td>
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Source: Midwifery Outcomes Report

4.2 When Midwifery Home Birth Clients Are Transferred To Hospital

Approximately 25% of the midwifery clients who choose to give birth at home require a transport to hospital.2 However, not every birth moved to the hospital is due to an emergency. In some instances, the labouring woman chooses to go to the hospital to access pain medications, or because labour is not progressing optimally. In these instances, the client and her midwife will discuss the options and make the decision together.
Some hospitals have developed protocols regarding communication between midwives and the hospital for cases of transfer. The AOM and the Ontario Medical Association (OMA) have developed guidelines that should be referred to by leaders and the maternity care team in order to establish appropriate protocols for home birth transfers (see Appendix I2: AOM/OMA Guidelines for Maternal/Neonate Transfers from Home to Hospital).

The CMO recommends that midwives communicate with Emergency Medical Services in advance, where appropriate, regarding a home birth to provide any information required to facilitate a timely transfer.

For more information on home birth, visit the AOM’s website at www.aom.on.ca or the CMO’s website at www.cmo.on.ca.

“Opposition to home birth… is not supported by Canadian evidence, which supports safe outcomes for mothers and infants when autonomous regulated midwives carry out home birth as part of a well-developed and supported system. The lack of consensus on the safety of home birth between disciplines should be addressed, because these disciplines need to cooperate in order to support what is an important part of midwifery practice. Women and infants should not be caught in interprofessional conflicts.”

– M. Klein et al. The Attitudes of Canadian Maternity Care Practitioners Towards Labour and Birth: Many Differences but Important Similarities, September 2009, JOGC.
Summary Of Key Messages

- Home birth with a registered midwife is safe for women who are experiencing healthy, low-risk pregnancies.

- Approximately 20% of Ontario midwifery clients give birth at home.

- Of those women who choose a home birth, approximately 25% require a transport to hospital. However, not every birth moved to the hospital is due to an emergency. In some instances, the labouring woman chooses to go to the hospital to access pain medications, or because labour is not progressing optimally.

- Appendix I2: AOM/OMA Guidelines for Maternal/Neonate Transfers from Home to Hospital should be referred to by hospital administrators and the maternity care team in order to establish appropriate protocols for home birth transfers.
Chapter 5: Liability
Chapter 5: Liability

5.1 Liability And Independent Practitioners

Ontario midwives are independent practitioners. The independent practice model provides for a distinction in law between the liability of midwives for the treatment of their clients, the liability of other independent health professionals, and the liability of hospitals for the management of the systems within which the treatment is administered.

Hospitals normally require proof of liability protection as part of the process for granting privileges for any professional staff, including midwives. The CMO has always required professional liability protection as a condition of registration.

5.2 Healthcare Insurance Reciprocal Of Canada Insures Midwives

Midwives currently practicing in Ontario have liability protection through the Healthcare Insurance Reciprocal of Canada (HIROC), the same insurance company many Ontario hospitals use. HIROC insures midwives in Ontario, Alberta, Manitoba, Saskatchewan, and Nova Scotia. HIROC has a long history in Canadian health care insurance, risk management, and claims management and conducts advocacy to benefit the health of Canadians in such areas as patient safety, interprofessional relations, client relations, and tort reform.

Having access to liability protection through HIROC provides midwives with ongoing access to educational forums and facilities, risk management teams, publications and other endeavours that HIROC engages in. For more information, visit www.hiroc.com.

Recommendations of the CMPA-HIROC Joint Statement

HIROC and the Canadian Medical Protective Association (CMPA) have created a joint statement to respond to questions from midwives and physicians who may treat the same client during the course of pregnancy, birth and the postpartum period (see Appendix D3: CMPA/HIROC Joint Statement on Liability Protection for Midwives and Physicians.) Among other things, the statement recommends that:

- Practitioners be familiar with the scope of practice of each team member (e.g., midwife, family physician, obstetrician) in the jurisdiction and institution in which they work;
Practitioners have an agreement about who is the most responsible care provider at any given time and what the division of responsibilities is at any given time;

Physicians contact the CMPA and midwives contact HIROC to discuss issues related to being part of a health care team or to learn the extent of assistance for clinics and other practice arrangements.

5.3 Accessing Client Records

HIROC recommends that all health professionals who have privileges at a hospital should have access to their client’s records in case they need to provide them to obtain legal advice with respect to an adverse incident, a disciplinary complaint, or a lawsuit.

Hospitals are urged to adopt a uniform approach so that midwives who have privileges are provided with the same access to records that physicians and other professional staff have in cases of adverse incidents, disciplinary complaints, and legal proceedings.

Further, the CMO quality assurance program’s practice audit requires access to client records.

5.4 Home Births And Liability

Midwives are required by the CMO to offer women a choice of birthplace (currently that choice is limited to home or hospital). This was established as a regulatory principle beginning in 1987 when the Task Force on the Implementation of Midwifery in Ontario addressed the question of how the Ontario health care system should respond to the growing interest in home birth.

The Task Force documented a consensus between the professions that if women choose home birth, they should be attended by well-educated midwives who have access to a hospital if complications arise, as is supported by the international research on home birth safety.

Home births continue to raise fears of liability for other health care practitioners. The following facts can assist in alleviating these fears:

- Hospital practitioners are not responsible for the care provided by the midwife prior to hospital admission.
- Each practitioner continues to be responsible for the care that he or she provides, not for the care given by other practitioners as outlined in Appendix D3: CMPA/HIROC Joint Statement on Liability Protection for Midwives and Physicians.
- The greatest risk with home birth transfers to hospital arises where there is poor communication between health care professionals. Developing communication protocols can help to minimize adverse outcomes (for example, establishing a protocol requiring midwives to call the hospital ahead of time regarding an impending transfer of care to a physician).

Midwives carry adequate liability insurance and are covered for both home and hospital births.

- Appendix G3: CMO Indications for Mandatory Discussion Consultation and Transfer of Care,
- Appendix I2: AOM/OMA Guidelines for Maternal/Neonate Transfers from Home to Hospital and
- Appendix D2: AOM/OMA Joint Statement of Professional Relations Between Obstetricians/Gynaecologists and Registered Midwives in Ontario are valuable tools for providing guidance to midwives, physicians, nurses and hospital leaders regarding the roles and responsibilities of midwives during a transfer of care to a physician, including during a move from a home birth to the hospital.
5.5 Strategies For Enhancing Safety And Quality Care During A Home Birth Transport

Strategies for Midwives

• Engage in clear and effective communication with all hospital staff and Emergency Medical Services (EMS) personnel to enhance the delivery of safe, quality client care.

• Be familiar with hospital protocols and prepare clients appropriately.

• Participate in the process to analyze and follow up on adverse events involving home birth transport.

• Establish positive relationships with all maternity care staff to help build an environment of respect, trust and open communication.

Strategies for Hospitals

• Develop protocols for the transfer of midwifery clients from home to hospital to ensure a respectful and efficient reception at the hospital.

• Develop communication protocols for all maternity care staff to enhance the delivery of safe, quality client care.

• Develop protocols for transfers of care with reference to professional standards.

• Develop a clear process to analyze and follow up on adverse events involving home birth transport.

• Ensure ongoing education for all maternity care staff about midwives, their role in home birth and home birth transport.

Strategies for the Transport System

• Support midwives requesting to direct EMS to the closest hospital or a hospital where they have privileges (see Appendix G1: Basic Life Support Patient Care Standards – Midwives at the Scene Standard).

• Develop criteria regarding decision-making for dispatch and midwives to assist in the transport process.

Strategies for Physicians

• Convey respect for the client’s choice to attempt a home birth.

• Build an environment of trust and open communication.

• Recognize midwives’ full role as primary care providers.

• Engage in clear and effective communication with midwives to enhance the delivery of safe, quality client care.

Developing communication protocols can help to minimize adverse outcomes for home birth transfers.

• Build an environment of respect, trust and open communication, ensuring that information sharing includes on-call staff.
5.6 Informed Choice And Midwives’ Liability

The informed choice process accepts that the client is the ultimate decision-maker. Sometimes, this means a client will make a choice counter to the midwife’s standards and advice. In recognition of this, the CMO has prepared a guideline for use by midwives in instances when a client chooses care outside of midwifery standards of practice or against the midwife’s recommendations (see Appendix F4: CMO Guideline on When a Client Chooses Care Outside of Midwifery Standards of Practice). This guideline provides resources for midwives to support a woman’s decisions after an informed choice discussion has taken place.

Summary Of Key Messages

• Midwives currently practicing in Ontario have liability protection through HIROC, the same insurance company used by many Ontario hospitals.

• Appendix D3: CMPA/HIROC Joint Statement on Liability Protection for Midwives and Physicians assures each provider that he/she is only responsible for the care that they provide to a particular client, not for the care provided by another health professional.

• Midwives’ liability insurance covers them for both home and hospital births.

• Developing communication protocols can help to minimize adverse outcomes for home birth transfers.
Chapter 6: Midwives in Hospitals
Chapter 6: Midwives in Hospitals

Introduction

Ontario hospitals have been working with midwives for 15 years, and hospitals that want to integrate midwives for the first time can benefit from this experience. The following information and leading practices may be useful in your hospital’s midwifery integration process. It is recommended that hospital processes for midwives are developed equitably and in alignment with those established for other practitioners.

6.1 Seven Steps To Bringing Midwives Into The Hospital For The First Time

Step 1: Review the MOHLTC’s Process for Funding New Midwifery Practices

Midwives or communities wishing to establish a new practice or grow an existing practice must secure approval and funding from the Ontario Midwifery Program of the MOHLTC through the submission of a proposal. The growth of midwifery is closely managed by the MOHLTC, which is in turn responsible for ensuring that midwifery directly supports its vision for the future of the health care system in Ontario.

The proposal must demonstrate the need for midwifery services in the proposed area, the availability of potential clients, and the capacity to attain hospital privileges to support the proposed midwifery service.

By the time a midwife applies for hospital privileges, a rigorous needs assessment has already been conducted by the MOHLTC.

The MOHLTC assesses each proposal and evaluates which ones will be funded based on meeting the following criteria:

- The community is experiencing an obstetrical provider shortage.
- There is an unmet demand for midwifery services in the community.
- There is the capacity within the practice group to function at an adequate size to provide on-call coverage, or they have the potential to do so in the future.

By the time midwives approach a hospital to apply for privileges, they have already undertaken a rigorous needs assessment process, including engaging community stakeholders, the TPA, and the MOHLTC, to establish the suitability of midwifery services to that area.

Currently, a hospital’s impact analysis, the Professional Staff Human Resources Plan, and the MOHLTC needs assessment process take place independently of one another. Since many of the criteria in these assessments are the same, consulting the MOHLTC process as a routine part of the hospital impact analysis and the Professional Staff Human Resources Plan will assist in ascertaining community need for midwifery services, as well as enable the hospital to harmonize its own plans for integration with the MOHLTC and LHIN strategies. Approximately 25% of planned home births are transferred to hospital, and hospitals should also take this into consideration when conducting the impact analysis for midwifery services.
Hospitals can anticipate that over time, established practices will most likely grow to meet the community demand for midwifery services, resulting in applications for additional privileges. Hospitals are encouraged to consider how the organization can support and sustain a workable call structure for the practice group over time within limited resources.

**Step 2:**

**Establish a Midwifery Integration Committee**

The successful integration of midwives into a hospital for the first time will be facilitated by the establishment of an integration committee. Suggested committee membership could include: local midwives, nursing staff, physicians (obstetricians, paediatricians, family physicians, anaesthetists), midwifery client representation, and administrative staff, as well as other hospital representatives from departments such as admitting, pharmacy, laboratory, public health, and home care liaison.

**Tasks of the Midwifery Integration Committee should include a review of the following documents:**

- The OHA’s *Resource Manual for Sustaining Quality Midwifery Services in Hospitals*
- The OHA’s *Hospital Prototype Board-Appointed Professional Staff By-law*
- The MOHLTC Needs Assessment of the midwifery practice being considered
- College of Midwives of Ontario documents, including Appendix G3: *CMO Indications for Mandatory Discussion, Consultation, and Transfer of Care*
- The *Midwifery Act, 1991* and the regulations under the Act (see Appendix H2: *Midwifery Act, 1991*)
- Regulation 965 of the *Public Hospitals Act (PHA)*
- *Regulated Health Professions Statute Amendment Act (Bill 179)* under the *Regulated Health Professions Act*
- *Excellent Care for All Act (Bill 46)*
- Current hospital Professional Staff Human Resources Plan
- Current labour and delivery policies and procedures
- Current hospital by-laws
- Clinical protocols
- Multidisciplinary Collaborative Primary Maternity Care Project (MCP²) Module on Communication ([www.mcp2.ca/](http://www.mcp2.ca/))
- Managing Obstetrical Risk Efficiently (MORE²) ([www.moreob.com](http://www.moreob.com))

**Recommended discussion topics for the Midwifery Integration Committee include:**

- Agreeing on tasks, goals, values
- Developing a timeline for the midwifery integration process
- Learning the approximate number of midwives who may be practicing in the area and their projected caseloads for the hospital
- Understanding the role and philosophy of midwifery care
- Determining how existing hospital policies will be applied to and/or modified for the practice of midwifery
• Determining the best means of integrating midwifery into the existing hospital governance structure (i.e., as a Division within Obstetrics/Gynaecology/Family Practice or as separate Department of Midwifery)

• Addressing the availability and accessibility of obstetrical, paediatric and anaesthetic care

Establishing an interprofessional Midwifery Integration Committee can facilitate a smooth and successful integration process for midwives and maternity care staff and can help to sustain quality midwifery services going forward.

Some tasks recommended for development include:

• Reviewing the hospital’s existing credentialing process and determining how that process would be applied to the credentialing and appointment of midwives

• Determining a process for obtaining Board approval for the addition of midwifery services

• Identifying how to amend hospital by-laws, staff rules, and clinical protocols to integrate midwifery practice

• Identifying the roles and relationships of maternity care providers

• Ensuring accessibility of physicians for consult and transfer of care, when needed

• Determining admission and discharge policies

• Identifying necessary protocols regarding midwifery care and home birth transfer to hospital

• Reviewing the hospital’s current compensation model for administrative work for all professional staff and ensuring a transparent process that is based on equitable principles

• Developing mechanisms to integrate midwifery into the labour delivery team to improve collaborative care and outcomes

• Ensuring that hospital services (i.e., blood bank) are accessible to midwifery clients for care in the hospital

Step 3:

Update Hospital By-Laws

If a hospital is integrating midwives for the first time, the hospital’s by-laws need to be amended to facilitate this integration.

Regulation 965 of the PHA provides that, where the hospital has midwifery staff, the by-laws should provide for: the organization of the midwifery staff, duties of the midwifery staff, and criteria with respect to the appointment and reappointment of members of the midwifery staff.

“The presence of midwifery at the hospital is reinforced by active participation in many committees. Whether it be establishing guidelines for newborn jaundice, pandemic planning or preparing for renovations, it is expected that midwifery may provide unique insights and will be present to work with the team.”

– Joyce Coombs, Former Head Midwife, Mount Sinai Hospital, Toronto
The Midwifery Integration Committee should determine which by-laws are applicable to midwifery staff. Integrating midwifery into existing hospital by-laws as far in advance as possible is important, as the hospital will not be able to offer privileges to midwives until these by-laws are in place. The by-laws should also address the following:

- Appointment and Reappointment to Professional Staff
- Term of Appointment
- Professional Staff Categories and Duties
- Monitoring, Suspension and Revocation of Privileges

Hospitals are encouraged to refer to the OHA’s Prototype Board-Appointed Professional Staff By-laws for guidance (http://www.oha.com/KnowledgeCentre/Library/Toolkits/Pages/Default.aspx).

3.1 Appointment and Reappointment to Professional Staff

When adding midwifery services, the hospital’s existing application process should be reviewed to determine how the process will be applied to midwifery staff. It is important to ensure an equitable process for how midwifery staff are granted privileges.

According to the PHA, the hospital application process for physicians includes the following requirements:

- Any physician may apply for appointment to the medical staff or for reappointment.
- The hospital must provide an application form to the physician upon written request.
- The application must be considered by the Medical Advisory Committee (MAC), which must give a recommendation to the board in writing within 60 days of the application.
- If the MAC recommendation takes more than 60 days, written reasons for the delay must be provided to the applicant and the hospital board.
- Written notice of the recommendation must be provided to the applicant and the board.
- Applicants must be informed they are entitled to written reasons for any rejection of privileges and can request a hearing before the board.

In general, it is recommended that procedures for midwifery applications to the hospital be the same as those in place for physicians. However, consideration must be given to the specific structure of midwifery practices and the model that requires the need to establish midwifery practices that are of a viable size in terms of providing intrapartum backup and a workable call structure.

3.2 Term of Appointment

Under the PHA, physician appointments to the medical staff are for a maximum of one year. After that, the physician must re-apply. Most hospitals apply the same terms of appointment to midwives in their by-laws.

3.3 Professional Staff Categories and Duties

Many hospitals use the same staff groups for midwifery staff as are used for medical staff. The use of associate staff appointments prior to active staff appointment is typical.
Rural midwives who serve a large catchment area often have privileges at more than one hospital. In these cases, the maternity care staff must be aware of the midwives’ administrative responsibilities and demonstrate flexibility given this situation. It is recommended that midwives and hospital leaders discuss the issue and address it through a policy on midwife participation and responsibilities.

3.4 Monitoring, Suspension and Revocation of Privileges

While the PHA only specifies the appeal process for physicians regarding appointment and privileges, many hospitals provide the same appeal process for midwives in their by-laws. This is recommended to maintain a consistent approach.

Pursuant to the PHA, the Board may revoke or suspend the appointment of a member of the medical staff. Many hospitals use the same criteria and process for suspension and reinstatement of privileges for midwifery staff as has been established for the medical staff and set out in the PHA.

A midwife in Ontario worked with her hospital to help change by-laws in a timely way so that midwives could be well integrated:

“In early 2007, when I was in the process of applying for funding from the Ministry of Health and Long-Term Care to start my practice, I approached the hospital to advise them of my plans. I told them that, if granted funding, I would be applying for privileges in the fall of that year. This gave them time to consider how midwifery would be integrated into the hospital and to take into account that there would need to be changes made to the by-laws.

After getting the funding, I filled out the application for privileges in October 2007. The hospital had basic by-laws in place for midwives but they were not very specific or tailored and did not make it easy for me to practice. The hospital struck a by-laws committee that had all the relevant people on it. The committee’s job was to go over the existing by-laws and to make recommendations for change.

I was invited to all the meetings of this committee and was able to give my suggestions. The committee looked at other hospitals in the region and sought information from the Association of Ontario Midwives and the College of Midwives. I contributed by-laws from other hospitals where they had midwives who ran solo practices [like me].

They also altered some of the categories for privileges to make it fit better for me (locum, student midwife, courtesy, etc). There were no limitations or conditions placed upon my scope of practice as defined by the CMO. After that, it went to the Board, which approved it in 2008. From the time I applied until the time I got privileges took eight months.”

– A northern Ontario midwife
Step 4: Develop Divisional/Departmental Policies and Protocols

The division or department should consider developing policies and protocols that address the following:

4.1 Admission, Discharge and Orders

The PHA enables midwives to admit clients and discharge clients, as well as write orders for the care of the client and newborns while in the hospital. To ensure clear communication among maternity care providers within the team, policies will need to be developed and made easily accessible to maternity care staff.

4.2 Clinical Protocols

Clinical protocols that will involve or impact midwives in the hospital will need to be developed and made easily accessible to maternity care staff. It is recommended that midwives be involved in the development of these protocols. Appendix C: Sample Protocols provides a variety of examples that can be referred to when developing these protocols.

4.3 Roles and Relationships

To facilitate the development of positive relationships between midwives and other maternity care providers and create an environment where midwives are well integrated into hospital birth units, it is important for staff in the department to understand the various roles and relationships that exist. Documentation outlining the specific roles and the expectations of relationships between midwives and maternity staff, supplemented by open discussion, will enhance interprofessional relationships (see Chapter 8: Interprofessional Collaboration in the Hospital).

“There is no area in health care that I can think of where the consequences of poor working relationships amongst providers can have as dire consequences, as in the birth of a child. Our experience in facilitating collaboration amongst caregivers in Birthing Units has demonstrated that, given the opportunity, there is frequently an expression of frustration with the status quo. Simply talking about expectations and perceptions has led to the subsequent development of quality improvement initiatives built on a clarification of roles and responsibilities and affirmation of the commitment to interprofessional collaboration.”

— Dr. Alan Stewart, Faculty of Health, York University
4.4 Policies and Protocols on Communication for Home Birth Transports

All women who plan for a home birth are made aware of the potential reasons for moving to a hospital through discussions with their midwife during their pregnancy. In some communities, midwives are required to notify Emergency Medical Services regarding the home births they attend, to facilitate a timely transfer if required.

Hospitals should develop policies and protocols regarding communications between midwives and the hospital during a home birth transport. The following resources can assist hospital leaders and the maternity care team in establishing appropriate policies and protocols:

- Appendix E1: CMO Policy for Ambulance Registration of Planned Home Births
- Appendix I2: AOM/OMA Guidelines for Maternal/Neonate Transfers from Home to Hospital

Step 5:

Develop Departmental Orientation for New Maternity Staff

Hospitals are encouraged to develop an orientation program for maternity staff, including newly-appointed midwives, to familiarize them with department-specific organizational structures, operations, policies and procedures.

The orientation program would likely include:

- Procuring identification badges
- Chart completion and documentation practices

Step 6:

Develop a Policy Regarding Additional Midwives in the Hospital

The Ontario midwifery model of care is delivered by a group practice which enables a viable on-call structure. In communities where the demand for midwifery services and birth numbers warrant it, hospitals can anticipate that established practices will bring new midwives into the facility to sustain this model of care and ensure access to midwifery services. Hospitals should understand that additional midwives may wish to join the practice over time.

In addition to maternity staff, hospitals are encouraged to educate other departments within the hospital that may come in contact with midwifery staff (e.g., Pharmacy, Lab, Ultrasound, Health Records) about the addition of midwifery services and how their department may be impacted. Midwives should similarly be oriented to these departments.
Step 7: Support Ongoing Integration

Successful integration requires ongoing attention and work. Specifically, there are two areas where hospitals can focus their efforts:

- Ensuring the Midwifery Integration Committee maintains its role and relevance
- Establishing a process for privileging mentored midwives

Maintaining the Role of the Midwifery Integration Committee

The following activities can help maintain the role of the Midwifery Integration Committee:

- Establish regular meeting times and agendas
- Establish the ongoing role of the committee
- Consider it as a standing agenda item at MAC, medical, departmental, and maternal and child program meetings
- Schedule regional or hospital ‘grand’ round presentations on midwifery
- Conduct periodic reviews of the integration process after a specific period of time, including input from all professional staff (e.g., physicians, nurses, midwives, respiratory therapists, social workers, nutritionists, pastors, public health, clerical staff, and support staff)

Establishing a Privileging Process for Mentored Midwives

The CMO requires newly-registered midwives (“new registrants”) to work for one year under the mentorship of an experienced midwife, and to attend at least 30 births during this time. In 2009-2010, the MOHLTC funded approximately 70 new registrants across the province. Consequently, hospitals can anticipate that they will receive privileging requests from these new registrant midwives.

The hospital and midwifery practice group are encouraged to discuss whether the privileges will be of a “rotating” nature (a different new registrant each year that will not stay on with the practice group), or if the midwifery practice group intends to keep the new registrant on. A timely process for privileging these new registrants, whether it be through locum, temporary or associate privileges, also facilitates new registrants’ integration.

For more information or for support during any of the stages of midwifery integration, hospitals can contact any of the midwifery stakeholders (see Appendix J3: Ontario Midwifery Organizations Contact List).

“The success of midwifery integration at Mount Sinai can be attributed to leadership and respect. This has involved midwives playing active leadership roles and also being clear that midwifery integration demands the leadership of medicine and nursing; to role model respectful collaborative relationships, to create infrastructures in the hospital that support full integration and collaboration, and a commitment to follow up when challenges occur. As well, there are policies specific to midwifery which clarify topics such as the midwifery supervision of new registrants and of midwives as they become experienced with epidural and oxytocin management. These policies are reviewed periodically to ensure that they reflect current practice.”

– Joyce Coombs, Former Head Midwife, Mount Sinai Hospital, Toronto
6.2 Hospitals And Midwives Are Working Together To Lead Integration

Perhaps the most important work in improving integration happens on the ground in hospitals, where the ongoing efforts of midwives, hospital leaders, and other maternity care providers are working to create change.

This intensive, usually voluntary work has yielded positive results. In fact, many of the leading practices listed in this Resource Manual have been drawn from the daily experiences of care providers and leaders determined to improve interprofessional collaboration and integration.

Examples of leading practices at work:

Managing Obstetrical Risk Efficiently (MOREOB) —The MOREOB Program is dedicated to improving and promoting patient safety in hospital obstetrical programs. Obstetrical health care providers are equipped with a comprehensive patient safety program that enables them to work efficiently and confidently together in a practice environment characterized by interprofessional collegiality, effective teamwork and communication. Hospitals that have implemented MOREOB have found it to have a positive impact on improving and promoting collaborative care. The MOREOB Program develops safety knowledge, skills, attitudes, behaviors and practices. Leading the implementation of this process in each hospital’s obstetrical unit is an interprofessional “Core Team” that includes family physicians, obstetricians, midwives, nurses, risk management personnel, senior hospital leaders and a hospital Board member.¹⁰ For more information, visit the MOREOB website at www.moreob.com.
“We were fortunate enough to be one of the first pilot sites for MORE™ at the Trillium Health Centre. Involvement in the MORE™ program and as integral members of the MORE™ Core Team helped an already strong interdisciplinary team to build skills and to develop an even stronger sense of teamwork and integration as we continue to move beyond the basic MORE™ modules into advancing MORE™.”

– Remi Ejiwunmi, RM and MORE™ Core Team Member, Trillium Health Centre

The Association of Ontario Midwives’ Interprofessional Relations Project — HealthForceOntario (HFO) is a provincial strategy designed to ensure Ontarians have access to the right number and mix of qualified health care providers. In 2008, the AOM received funding from HFO to undertake an initiative bringing maternity care practitioners together to enhance relationships and address challenges in eight hospitals in the province. Appendix D1: AOM Interprofessional Relations Project describes the work conducted by the Guelph General Hospital, which involved several intensive education and team-building exercises with its maternity care team, and the creation of new institutional structures to improve communication at the hospital.

Risk Management Self-Appraisal Modules (RMSAM™) — The RMSAM™ is a self-appraisal tool that incorporates emerging risk exposures based on claims experience, case law, leading practices and legislation. Hospitals can use the RMSAM™ as a foundation for starting up risk and safety programs, and can include the Maternal-Newborn Module specific to maternity care. Midwives in several Ontario hospitals have participated as members of the obstetrical team in the completion of this module. Midwifery practice groups participate in completing RMSAM modules which have been adapted to address business and clinical risks in the provision of out-of-hospital midwifery care. More information about the RMSAM™ can be found at http://www.hiroc.com/rmsam_overview.asp.

Summary Of Key Messages

- By the time a midwife applies for hospital privileges, a rigorous needs assessment has already been conducted by the MOHLTC.
- Establishing an interprofessional Midwifery Integration Committee can facilitate a smooth and successful integration process for midwives and maternity care staff and can help to sustain quality midwifery services going forward.
- There are a number of divisional/departmental policies and protocols that need to be established to ensure all staff members within a division or department are aware of how to proceed in a given situation.
- All new maternity care staff would benefit from a department-specific orientation program to familiarize them with specific operations, policies and procedures within their division or department.
- Hospitals are encouraged to educate other departments within the hospital that may come in contact with midwifery staff about how the addition of midwifery services will impact their department.
- The most important work in improving integration happens on the ground in hospitals, where the ongoing efforts of midwives, hospital leaders, and other maternity care providers are working to create change.
Chapter 7: Midwives and the Hospital Accountability Structure
Chapter 7: Midwives and the Hospital Accountability Structure

Introduction

Hospitals integrating midwifery services most successfully are those that create opportunities for obstetricians, paediatricians, family practitioners, anaesthetists, midwives and nurses to establish standards of maternal and newborn practice. They implement peer review mechanisms to ensure continuous quality of care, multidisciplinary teaching opportunities and evaluation studies to review outcomes of care.

While midwives, like physicians, are not hospital employees and have their own liability insurance, the hospital is responsible for the quality of care that is provided to its patients. Similarly, midwives are professionally accountable for the quality of care they offer to their clients. The hospital, in turn, ensures that providers in the hospital are competent and can offer safe, quality patient care. As such, when midwives gain hospital privileges, they become part of the hospital accountability structure in the same way that physicians do.

7.1 Options For Integrating Midwifery Into Existing Hospital Governance Structures

Currently in Ontario, there are three ways in which midwifery services are generally integrated into the hospital governance structure:

1. Divisional Structure

Where a Department (i.e., Obstetrics/Gynaecology or Family Medicine) is divided into Divisions, a Division of Midwifery is established, led by a Head Midwife.

Figure 4: Divisional Structure

The Head Midwife is responsible for the supervision of the quality of midwifery care provided in the hospital and reports to the Chief of the Department.

2. Departmental Structure

A Department of Midwifery is established, led by a Chief of Midwifery.
Figure 5: Departmental Structure

The Chief of Midwifery is responsible for the quality of midwifery care and reports to the Chief of Staff.

3. Programmatic Structure

In hospitals where a programmatic structure exists, midwifery services are provided through one of the various programs offered by the hospital.

Figure 6: Programmatic Structure

7.2 Key Roles And How They Relate To Midwifery Integration

The following descriptions of key roles may or may not apply for every hospital, however, the purpose of providing the descriptions is to present a general overview of the key roles which hospitals can customize and adapt depending on local circumstances.

Head Midwife or Chief of Midwifery

The Head Midwife is responsible for facilitating midwifery input into relevant committees and decision-making structures, and for representing the midwifery perspective. Where appropriate, the Head Midwife may also provide input to the Chief of the Department when making strategic decisions regarding issues such as resource allocation and protocol development. This helps to ensure the midwifery program is managed effectively and is aligned with the overall clinical management system of the hospital (see Appendix C11: Criteria for Head of Service for Midwifery).

Where there is a Chief of Midwifery, he/she is responsible for making strategic decisions regarding issues such as resource allocation and protocol development. This allows midwives to manage their practices effectively and within the overall clinical management system of the hospital.

Related Clinical and Administrative Leaders

Regardless of the hospital-specific organizational structure used to integrate midwifery services into the hospital, the role of other related clinical or administrative leaders (e.g., Chief of Obstetrics/Gynaecology, Chief of Staff, Medical/Clinical Director, Vice President of Medical Affairs) relative to midwifery integration is largely to support the integration.
process. There are a number of factors that are integral to this process because they help establish and promote a positive working environment and attitude among staff. Hospital leaders can support integration by:

**Promoting Safe and Quality Care**

- Working together with staff to ensure consistent standards for the provision of care for both mother and newborn.
- Negotiating and approving clinical, consultation and transfer of care protocols among midwives, obstetricians, family physicians, and paediatricians.
- Advancing hospital privilege applications and reapplications and helping to make decisions about those applications.
- Developing quality of care and resource indicators and a framework to monitor and evaluate progress.

**Sharing Knowledge and Providing Ongoing Education**

- Being knowledgeable about the regulated midwifery scope of practice and how it intersects with obstetricians, family physicians, paediatricians, anaesthesiologists and other medical staff.
- Having an understanding of the hospital by-law formats that accommodate midwifery.
- Building relationships with colleagues who have successfully integrated midwifery into their hospital.
- Developing a framework for ongoing professional development for all practitioners.
- Providing ongoing education and ensuring the involvement of staff in orientation and information sharing.
- Communicating to the community the hospital’s provision of midwifery services.
- Fostering Positive Relationships Among Staff
- Maintaining regular meetings with the departmental staff, including midwives.
- Establishing the role of nursing in regard to midwifery.
- Providing a comprehensive orientation for all professional staff, including midwifery.

**Optimizing Available Resources**

- Working together with staff to meet human resource needs and participate in resource allocation decisions.
- Determining the impact of midwifery services on operations (e.g., volumes, patient flow, equipment and resource usage, diagnostics, pharmacy).

Recognizing that governance structures will vary across hospitals depending on size, service characteristics and local circumstances, the specific responsibilities undertaken by the key clinical and administrative leaders will also vary.

**Chief Executive Officer**
The Chief Executive Officer (CEO) is responsible for supporting the hospital’s strategic directions, providing optimal patient care while ensuring operational effectiveness within an integrated health care system and creating a positive and invigorating environment for hospital staff.

Regardless of the organizational structure of the hospital, the CEO’s role relative to midwifery integration, is largely to support the process by creating
a constructive environment and promoting a positive attitude among all professionals involved, similar to other hospital leaders.

However, the CEO achieves this goal by:

- Setting expectations for interprofessional practice throughout the entire organization.
- Reinforcing the goals of patient safety, access to care and the patient’s right to choice of provider.
- Identifying the resource implications of midwifery services.
- Ensuring effective human resource planning, including planning for obstetrical needs.
- Ensuring that there are structures and systems for the development, review and recommendation of new programs, program expansion or changes (including midwifery).
- Communicating with related health care agencies to ensure co-ordination and/or planning of local health care services that impact midwifery services (e.g., midwifery Transfer Payment Agencies, community health centres, LHINs).

The Board of Directors

The responsibility for advancing quality and safety in the hospital requires thoughtful leadership and oversight by the hospital’s Board of Directors. Under the PHA, the Board of Directors is responsible for the by-laws that provide for the organization of the professional staff, including criteria for the appointment and reappointment of members of the professional staff, and revoking or suspending appointments, including midwives.

The Board of Directors also holds ultimate responsibility for approving the appointments of midwives to the professional staff of the hospital, and for revoking, suspending or refusing the reappointment of midwives. The hospital, through its Board, must exercise due diligence in the appointment process. An effective process for peer review should exist, both initially and ongoing. It is important to thoroughly evaluate applicants to ensure all appointed and reappointed staff are providing safe, quality patient care.

The Board’s role, relative to midwifery, is to ensure the hospital has appropriate programs and services to meet the needs of the community, within available resources, and in alignment with the vision and strategic plan of the organization. The Board is responsible for ensuring that the quality of patient services provided by their hospital is monitored and that the services meet the standards expected by the community it serves.

7.3 Involving Midwives In Hospital Programs And Committees

All hospital, medical, dental and midwifery staff members have obligations and responsibilities to participate in hospital programs of quality improvement, risk management, utilization review, ethics, education, and research.

Involving midwifery representation in programs and committees that impact midwifery services is essential for leaders to make effective and informed decisions.
MACs are responsible for the review of all professional applications for privileges in Ontario hospitals, including midwifery. Regulation 965 of the PHA states that the MAC shall make recommendations to the Board concerning the quality of care provided in the hospital by the medical, dentistry, extended class nursing and midwifery staff. Some hospitals have found it useful to include midwives on the MAC. These hospitals do so by amending their by-laws to include non-physician participation on the MAC. Midwives report that this has resulted in better communication among MAC participants and enhanced interprofessional relationships.

Summary Of Key Messages

- Recognizing that hospitals vary in size, service characteristics and community needs, there are a number of options for integrating midwifery services into the hospital governance structure.
- Regardless of organizational structure, understanding where midwives fit within hospital governance helps to successfully integrate midwives into the hospital accountability structure.
- Involving midwifery representation in programs and committees that impact midwifery services is essential for leaders to make effective and informed decisions.

Having a Midwifery Member on the MAC – One Practice Group’s Experience

“The hospital changed its by-laws to allow for the development of a department of midwifery one year after our practice received privileges (2001). As a result of the change of the by-laws and the creation of the Department of Midwifery, it made sense that a midwife would participate on the Medical Advisory Committee (MAC).

Having a midwife attend MAC meetings has definitely benefited us in terms of collegiality and respect from other health care providers. In addition, the MAC allows us to work with physicians we don’t work with that often. In the end, clients benefit from those relationships.

The MAC is good for working out privileging problems also. Everybody at the table has an opportunity to speak and to hear from all of the other professions in the hospital.”

– Alison Lavery, RM and Lisa Morgan, RM, Cambridge Midwives
Chapter 8: Interprofessional Collaboration in the Hospital

Introduction

Interprofessional care encompasses partnership, collaboration and a multi-disciplinary approach to enhancing care outcomes and is a key component of the MOHLTC strategy to optimize health human resources.

The midwifery model of care is collaborative and involves ongoing dialogue and relationships with other members of the maternal-newborn team.

Maternity care provision in a hospital will directly involve midwives, nurses, obstetricians, anaesthetists, family physicians, paediatricians and others. It is essential that the various maternity care providers work collaboratively to deliver the best quality of care in every health care setting. The roles of key professions involved in a midwife-attended hospital birth are outlined below.

“Supportive working relationships do not happen by accident. Hard work is required to establish and maintain such a working environment; ongoing challenges continue to emerge and require troubleshooting. There is no chance to be complacent and assume that good relationships are self-perpetuating once established. They take ongoing work, dialogue and leadership.”

– Joyce Coombs, Former Head Midwife, Mount Sinai Hospital

8.1 Working With Nurses

Nurses are often the backbone of maternity care services in a community. They have a wide variety of responsibilities in terms of care during pregnancy, childbirth and the postpartum period. In addition, nurses working in maternity care units have traditionally held the responsibility of providing labouring women with clinical and emotional support.

“The nursing staff at the two hospitals I work at have often been my lifeline to learning how to work in new hospitals. Over time, we developed a great team relationship that has resulted in excellent patient care. We share a common goal of respectful and safe care.”

– Andrea Cassidy, RM, Midwifery Collective of Essex County
This has changed with the integration of midwifery care into the hospital and continues to evolve as scopes of practice are changed to optimize health human resources. Nursing staff may have a less intensive role in the care of a midwife’s clients as compared to the care of a physician’s patients for the following reasons:

- The current model of midwifery care requires two midwives be in attendance at every birth, or, where the practice group is very small, one midwife and a qualified second birth attendant (see Appendix F6: CMO Guidelines for the Second Birth Attendant, Appendix C2: Attendance at Midwifery Births, Appendix C7: Nurse as Second Birth Attendant for Midwifery Delivery).

- Midwifery clients who are planning a hospital birth usually spend most of their early labour at home, and arrive at the hospital in active labour.11

- Fewer midwifery clients request pain relief.12

- Upper level midwifery students often attend births and contribute to support measures for the woman.

- Midwives provide much of the support and comfort measures throughout labour and delivery that nurses may provide for physician-attended births.

As there continues to be a high level of collaboration between nurses and midwives in the provision of maternity care in Ontario hospitals, a positive relationship between nurses and midwives is essential to providing safe, high-quality maternity care.

For example, in some communities, the hospital approves the use of nurses on staff at the hospital to regularly act as second attendants for midwifery births (as opposed to another midwife acting as the second attendant, which is common in most communities). The role of the nurse and the midwife in these hospitals will be similar to that of the nurse and the physician on the labour and delivery unit. Hospitals may wish to consult Appendix F6: CMO Guidelines for the Second Birth Attendant when developing role descriptions (see also Appendix C7: Nurse as Second Birth Attendant for Midwifery Delivery).

“When we first moved to Mount Sinai, shifts were done with nurses to establish an understanding of how they work and to familiarize the midwives with some of the practices at the hospital. Midwives regularly participate in the orientation of nurses new to the perinatal program and speak to each class of medical clerks and residents.”

– Joyce Coombs, Former Head Midwife, Mount Sinai Hospital, Toronto

To ensure the delivery of care is safe and equitable for all patients in the hospital, protocols and policies for midwifery clients should be consistent with those of non-midwifery clients.

Additionally, if the client remains in the hospital after the birth, midwives will leave orders for their care. In such cases, it is appropriate for the nurse to carry out the orders in the midwife’s absence, as they would when a physician is the primary care provider.

Midwives remain on-call for their clients during the postpartum period. Hospital protocols for communicating with midwives and midwifery clients in the postpartum period can facilitate improved collaboration (see Appendix C6: Interaction of Nurses and Midwives).
Chapter 8: Interprofessional Collaboration in the Hospital

The relationship between midwives and nurses is essential. Generally, respectful, trusting, and understanding relationships are supported through the collaborative development of comprehensive role descriptions for each profession, including clarity regarding professional responsibility and accountability. Midwives and nurses are encouraged to familiarize themselves with each other’s scope of practice, engage in open discussions about roles and responsibilities and establish communication protocols to facilitate and support the development of the relationship (see Appendix C6: Interaction of Nurses and Midwives, Appendix C7: Nurse as Second Birth Attendant for Midwifery Delivery and Appendix C8: Nursing Guidelines of Midwifery Clients not in Labour with Term PROM, GBS+, Prolonged Ruptured Membranes).

Appendix D2: AOM/OMA Joint Statement of Professional Relations Between Obstetricians and Registered Midwives in Ontario outlines the major shared principles that can facilitate collaboration between midwives and obstetricians, including clear mechanisms for consultations and transfers of care. In addition, Appendix G3: CMO Indications for Mandatory Discussion, Consultation and Transfer of Care (IMDCTC) sets out the clinical indications for which a midwife is required to involve a physician (usually an obstetrician), either through a consultation or a transfer of care.

Payment for obstetricians who provide consultations for midwives is described in the MOHLTC’s Schedule of Benefits: http://www.health.gov.on.ca/english/providers/program/ohip/soh/physerv/physerv_mn.html.

“Change is hard for anybody. People are vulnerable about their roles. It can be difficult to negotiate the role definitions – we’re always working on that with doctors and nurses and midwives. It takes goodwill on all sides and really working together for awhile at any site.”

– Carol Cameron, RM, Midwifery Services of Durham, Markham Stouffville Hospital

8.2 Working With Obstetricians

Collaboration with obstetricians is integral to the provision of midwifery care. Although midwives provide care for healthy, low-risk pregnancies, some pregnancies and births may encounter complications. In these cases, the midwife will consult with an obstetrician and sometimes transfer care.

The relationship between midwives and obstetricians, either in the community hospital or nearest referral center, is essential to providing safe, primary maternity care.

“Excellent interprofessional relationships amongst the maternity care providers in the region are a reason why we can sustain birth on Manitoulin Island. When there are complications or situations that go beyond the midwifery scope of practice, there are two OBs in Sudbury that can be phoned and consulted with. We have the same good relationship with a paediatrician in Sudbury. The family physicians on Manitoulin, at Little Current, can also be consulted. These good relationships make birth on Manitoulin Island possible.

We also have a good system of transport for when there are complications. One-third of births end up being transferred to Sudbury (level 2). If during labour it’s clear that someone is not coping well, and that they might benefit from an epidural, then I will transfer. With the helicopter pad on top of the hospital, the actual time out of hospital for transfer [to Sudbury] is 40 minutes. If weather conditions are bad, or for other crisis situations, we have to go by ambulance and send a nurse or the midwife or the doctor with the patient. It takes one and a half hours by land to Sudbury.”

– Mary Buie, RM, Manitoulin Island
8.3 Working With Family Physicians

Since both professions focus on low-risk births, midwives and family physicians rarely work together, as to do so would be duplicative. One current exception is in some remote hospitals where there is a limited number of births and where midwives and family physicians have developed an arrangement to share call to sustain maternity care in their community.

As well, midwives and family physicians have referral relationships. In many cases, family physicians that do not practice obstetrics will refer their clients to the local midwifery practice group. To ensure open channels of communication between the midwife and the family physician, midwives are encouraged to communicate with their clients’ family physicians at the outset of care (see Appendix C12: Template Letter from Midwife to Family Physician (Outset)). Similarly, when the midwife is preparing to discharge her client and the baby at six weeks postpartum, she may either refer the client to a family physician or provide a letter of transfer to the woman’s family physician with relevant information about the baby and birth (see Appendix C13: Sample Letter From Midwife To Family Physician (Completion of Care)). Where possible, the hospital should facilitate the development of these relationships between midwives and family physicians.

Payment for family physicians who provide consultations for midwives is described in the MOHLTC’s Schedule of Benefits: [http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html](http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html).

8.4 Working With Paediatricians

The CMO’s IMDCTC includes indications related to the newborn where the midwife must consult with, or transfer care to, a physician, including paediatricians (see Appendix G3: CMO Indications for Mandatory Discussion, Consultation and Transfer of Care). While consultations with paediatricians occur less frequently than those with obstetricians, the relationship between midwives and paediatricians remains an integral part of midwifery care.
Appendix I2: AOM/OMA Guidelines for Maternal/Neonate Transfers from Home to Hospital may be consulted when developing or revising protocols for consult and transfer to a paediatrician. As well, hospital rules must include the process for consultation between midwives and paediatricians.

8.5 Working With Anaesthetists

Midwifery births will involve collaboration with an anaesthetist when the client requests an epidural (which happens in approximately 15% of midwifery births13), or when a client requires a Caesarean section. In the latter case, the care will have been transferred to an obstetrician and the midwife remains with the client to provide supportive care and to receive the baby.

Occasionally, a midwife will assist at a Caesarean section, under delegation of a physician. In all of these cases, midwives and anaesthetists will need to collaborate in the care of the client. Hospitals and practitioners should refer to Appendix F5: CMO Guideline to Antepartum Consultations for Clients of Midwives to Anaesthesia.

Anaesthetists are paid for MRAs that take place in hospital. The MOHLTC’s Schedule of Benefits provides more information about payment for anaesthetists who provide services to midwifery clients: http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html.

8.6 Working With Paramedics

An ambulance may be called to a home birth to facilitate transfer in a number of situations. Some of these situations are urgent and require transfer to the nearest appropriate facility; however, most transfers by ambulance are not an emergency, but are a prudent measure taken by midwives to ensure safety. For example, most home birth transports involve the need for pain relief or augmentation of labour. In these cases, the client would most appropriately be transferred to the facility where the midwife has privileges. Bringing the labouring woman to a hospital where her midwife has privileges in non-emergent situations preserves continuity of care.

In these non-emergent situations, the decision about where to transport the labouring woman is most appropriately made by the midwife who has been trained to make important clinical decisions, in consultation with the ambulance personnel. The CMO provides a framework for communicating with Emergency Medical Services if necessary (see Appendix E1: CMO Policy for Ambulance Registration of Planned Home Births).

Section 5 of the Basic Life Support (BLS) Patient Care Standards for ambulance personnel relating to obstetrical conditions, contains a Midwives at the Scene Standard, that requires paramedics and midwives to work cooperatively in making decisions and providing quality patient care to the mother and neonate during an out-of-hospital birth (see Appendix G1: Basic Life Support Patient Care Standards – Midwives at the Scene Standard).
Communication and Protocols

Midwifery practices should establish a professional relationship with ambulance service operators within their catchment area to ensure all personnel are aware of how to proceed during home birth transports. Educational sessions or discussions between midwives and ambulance personnel may facilitate this, including topics such as:

- the training of midwives
- the equipment carried to home births
- the monitoring and risk assessment that takes place during labour at home
- midwives’ hospital privileges in the catchment area of the ambulance service

To ensure consistency for each request for ambulance transport from a home birth, a standard procedure should be established by the hospital, the midwifery practice and the ambulance service. Important information to consider when establishing a standard procedure can include, but is not limited to:

- an explanation of the reason for transport;
- the urgency of the situation; and
- the midwife’s recommendation for facility choice, based on the reason for transport, urgency and available services and personnel at the hospital(s) in the community.


8.7 Interprofessional Care In Rural And Remote Communities

Midwives have an important role to play in the delivery of maternity care in hospitals that are located in remote and under-serviced communities.

Midwives can be critical in sustaining local obstetrical units in rural and remote areas as the number of family physicians providing maternity care services continues to decline. Increasing the use of midwives in these areas will also support women who wish to give birth as close to home as possible.

The MOHLTC recently funded various incentive programs for rural and remote midwives to help make midwifery practice more sustainable in these areas and to allow women with low-risk, normal pregnancies to remain in their communities.

In communities with small numbers of maternity care providers, midwives may be transferring the care of clients to general practitioners rather than obstetricians, when the care of the client falls outside of their scope of practice.
In these communities, it is advisable that midwives and general practitioners develop protocols regarding their respective roles in midwife consultations. This may include designating the limits of the general practitioner’s expertise regarding clinical indications that midwives consult for (see Appendix G3: CMO Indications for Mandatory Discussion, Consultation and Transfer of Care).

**Shared Primary Care**

In some instances, a midwife and a physician may share the primary care of a woman during pregnancy, delivery and the postpartum period. Shared care arrangements may be necessary in geographically isolated regions of the province, or when serving a population with special needs. A complete list of the CMO’s criteria for approving shared care arrangements can be found in Appendix G7: CMO Standard on Shared Primary Care, which states “In limited circumstances, approved by the College of Midwives of Ontario, primary care may be shared by midwives and another regulated primary health care provider. Shared primary care shall be provided in accord with the Philosophy of Midwifery Care in Ontario and the Code of Ethics of the College of Midwives of Ontario. It should be clear which health professional is the most responsible, and known to all, especially the woman, and be clearly documented in the client record.”

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**A Working Model of Interprofessional Care in a Remote Community**

Melanie Guerin is a solo midwife who works in a remote Francophone community. Melanie cares for about 30 women per year with low-risk pregnancies, and their newborns. She has a “second birth attendant”, as a part of her practice’s funding from the Ontario Midwifery Program, who does intrapartum care with her.

The second attendant goes to home births with Melanie or, if the woman prefers a hospital birth, she will join Melanie at the hospital. If the second attendant is unavailable when a client is in labour, the hospital provides nursing backup for Melanie. Melanie shares call with a family physician, Dr. Richard Claveau, when either is off call.

“If I know I’ll be away when someone is due, I’ll get her to meet with Richard maybe once or twice during her care so she is familiar with him and vice versa.” Melanie and Richard also work out of the same office in the community and collaborate on a regular basis. “I use him for consults. I discuss cases and conditions with him that I would normally discuss with another midwife. For high-risk births, locum surgeons are available most weeks of the year.”

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**8.8 Four Strategies To Overcome Challenges To Interprofessional Collaboration**

Given the highly collaborative nature of midwifery care, and the relatively new incorporation of midwives into many hospitals, it is not surprising that there are sometimes challenges in interprofessional relationships. It is important to realize that interprofessional collaboration is an ongoing process.
Below are strategies for midwives and hospital leaders to consider when striving to overcome some of the common challenges that arise with interprofessional care.

1. Clarify perceptions regarding liability
Some physicians may be concerned that they will be liable for any negative outcome of midwifery births with which they have been involved. However, midwives are fully insured under HIROC and physicians are not responsible for care given by another provider. The Canadian Medical Protective Association (CMPA) and HIROC have developed a joint statement that responds to questions from midwives and physicians who may treat the same client during the course of pregnancy, birth and the postpartum period (see Appendix D3: CMPA/HIROC Joint Statement on Liability Protection for Midwives and Physicians).

An educational round on this topic for members of the maternity care team, which might include representation from HIROC, and/or CMPA, should be offered periodically. As well, education on midwifery’s clinical outcomes may be beneficial in alleviating some physician concerns. For more information, see Chapter 5: Liability or visit HIROC’s website at www.hiroc.com.

2. Clarify perceptions regarding safety
There may be a perception that midwifery care is not as safe as the care provided by a family physician or an obstetrician, or that midwives do not have rigorous training.

In these cases, education about midwifery training, philosophy, and outcomes is essential. Representatives from the AOM, the CMO and HIROC have all been involved in such educational rounds in the past, and can act as resources for future education.

3. Engage in dialogue regarding competition for births or procedures
While competition among primary maternity care providers varies across the province, it is a real phenomenon in some communities.

In larger hospitals where there are many births, women have a right to expect a choice of care provider, which can lead to the perception of competition. To minimize the level of perceived competition and avoid unintended consequences, hospital decisions on the privileging of providers should be transparent and based on equitable principles. When the focus is on meeting the client’s needs to provide patient-centered care, competition among primary maternity providers in these communities may become less of an issue.

4. Clarify perceptions regarding payments for consultations
A common misconception exists among some specialist physicians that they will not be paid for midwifery consults in the hospital.
In fact, the MOHLTC’s Schedule of Benefits for physicians involves payments for MRAs for in-hospital consults with family physicians, obstetricians, anaesthetists and paediatricians, and for out-of-hospital consults with obstetricians. Lengthier consultations (50 minutes or more) are paid at a higher rate. All maternity care providers should be educated about this schedule of fees. For more information, see Section 1.6: How Midwifery Services are Funded or visit the MOHLTC’s website at http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html.

In general, hospital leaders and health care professionals need to strive for excellence in communication to make the maternal-newborn unit a safe and effective working environment.

According to the national Multidisciplinary Collaborative Primary Maternity Care Project (MCP²), “team members need to acknowledge that effective communication requires significant time commitment and investment. This is both structured time commitment such as meetings each week, and unstructured time through social interaction. Both time investments are important for building rapport and respect. The ideal form of communication is face-to-face…regardless, ongoing communication in any form is essential.”

Summary Of Key Messages

- Midwives can direct an ambulance to the appropriate facility during a transport from a home birth, with ambulance dispatch confirmation.

- Midwives are encouraged to communicate with their clients’ family physicians (if applicable) at the outset and upon completion of the course of care.

- Midwives have an important role to play in the delivery of maternity care in hospitals that are located in remote and under-serviced communities.

- To ensure the delivery of care is safe and equitable for all patients in the hospital, protocols and policies for midwifery clients should be consistent with those of non-midwifery clients.

- In communities with small numbers of maternity care providers, midwives may be transferring the care of clients to general practitioners rather than specialists, when the care of the client falls outside of their scope of practice.

- In hospitals where effective communication exists, policies and protocols have contributed to and supported the flow of information and the development of mutual respect among staff members.

The MCP² Module on Communication is a useful resource that hospitals may wish to consult. It can be accessed at http://www.mcp2.ca/english/documents/J-Mod4CommunicatingFFinal8May06.pdf.