ASSOCIATION OF ONTARIO MIDWIVES

Represents Registered Midwives and Promotes the Profession of Midwifery in Ontario

Midwives and Interprofessional Care

Association of Ontario Midwives

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Midwives and Interprofessional Care

Executive Summary

In “Midwives and Interprofessional Care”, the Association of Ontario Midwives (AOM) outlines our support regarding interprofessional care (IPC) in the provision of maternity care in Ontario.

We begin by presenting a snapshot of the need for maternity care providers in Ontario, which is the context that must drive this health reform. Both the AOM and the Ontario Medical Association agree that by 2012, without addressing the shortage of providers, there may be at least 10,000 women who will not have a maternity care provider for intrapartum care.[1] In addition, consumer demand for midwifery far outpaces supply. In 2005-06 for example, 16 409 women requested midwifery care but only 10 403 were able to access care.

Interprofessional care is one important response to current and looming unmet maternity needs and we propose six concrete recommendations that will enable IPC.

Specifically, we recommend that the Ontario Ministry of Health and Long-Term Care:

- Earmark specific funds to support IPC pilot projects in communities that possess both the need and the providers willing to participate. Pilot projects will enable thorough evaluation and relevant “lessons learned” for subsequent initiatives.

- Update the *Public Hospitals Act* to ensure midwives are guaranteed due process and right of appeal concerning hospital credentialling and representation on committees that determine credentialling.

- Direct LHINs to establish consistent guidelines for the integration of midwives into all hospitals that offer maternity care, including guidelines for credentialing and guidelines that ensure midwives are able to work to their fullest scope possible. Midwives must be able to work to their full scope in order to be fully integrated into hospitals and to fully participate in IPC models. Direct LHINs to offer incentives to hospitals that fully integrate midwives.

- Create funding mechanisms for compensating midwives involved in IPC models that are equitable both within new IPC models and also with midwives working in the current Ontario model. Adequately compensate obstetricians to provide on-call back-up for consultations and referrals from midwives. Physicians must be compensated to be available for high-risk transfers of care. Likewise, other specialists such as pediatricians or anesthetists need to be compensated for direct referrals from midwives.

- In conjunction with the Ministry of Training, Colleges and Universities, earmark funds to enhance interprofessional education within the Midwifery Education Program (MEP) for midwifery students, medical students, residents, nursing students and other health care providers. The MEP, at each of its three sites at Ryerson, McMaster and Laurentian is an ideal group to provide interprofessional education with a specific focus on maternity care.

- Fund birth centres for low-risk normal birth and as model sites of interprofessional education and practice. Interprofessional education is essential to the success of IPC and birth centres offer an ideal environment for providers to learn from, with and about each other.

Action on these six recommendations will enable midwifery participation in interprofessional care in Ontario.

In addition, the AOM provides comprehensive steps for building a strong foundation upon which successful IPC initiatives can flourish. This foundation must be constructed by stakeholders to ensure the long-term success of IPC. The critical foundational elements for successful IPC initiatives include:

- Recognizing collaboration is an essential precondition for successful IPC.

- Visionary approaches to IPC that include midwives as team leaders.

- Ensuring IPC teams are well planned, structured, funded and integrated into the communities they serve.

- Understanding significant barriers to IPC exist in current legislation, including the *Public Hospitals Act*, but that not all regulation is a barrier. The road to effective IPC is through the strengths and opportunities available within professional self-regulation. However, regulation must keep pace with changes in clinical practice. For example, enabling midwives to order appropriate diagnostic testing for conditions within their scope of practice enables midwives to respond to client needs as primary providers within a team setting.

- Enabling multiple and flexible IPC models that reflect the specific needs of individual communities.

- Addressing funding barriers to IPC. Ontario midwives support the quality of care facilitated by the current model of practice which is enabled by course of care funding. Additional funding models and mechanisms are needed that enable IPC.

- Valuing interprofessional education and ensuring providers encounter midwives working to the broadest possible scope.

- Recognizing that increased collaboration between providers leads to improved risk management by enhancing the familiarity, understanding and comfort with the scope of practice of providers from various professions.

These eight foundational elements are informed by the comprehensive work of the Multidisciplinary Collaborative Primary Care Project (MCP2) and the Ontario Maternity Care Expert Panel (OMCEP). Both MCP2 and OMCEP provide excellent guides to enabling IPC initiatives.

Conclusion

The AOM supports IPC initiatives and recognizes the potential of IPC initiatives to meet the needs of diverse communities. IPC initiatives hold the potential of addressing current and looming gaps in care and of keeping maternity care as close to home as possible. To that end, the AOM is committed to working with the MOHLTC and maternity care stakeholders to further IPC in maternity care in Ontario.

Introduction

The AOM supports the introduction of new IPC models and initiatives in the provision of maternity care in Ontario.

IPC appears in many reports on health reform as a key solution to the challenges of the Ontario and Canadian health care systems.[2] For example, the Health Council of Canada identifies the need to promote the "...*huge potential [of IPC] to make our health system more sustainable, more effective, and more responsive to population health needs"* (2005: 25).

In addition to reports identifying IPC as an important reform for the entire health system, there have also been national[3] and provincial[4] reports that focus specifically on maternity care. These reports describe the approaching maternity care crisis in Ontario and Canada-wide; providing thoughtful discussions of IPC as an important and timely response.

The need for additional maternity care providers and the need to ensure women can access maternity care close to home demands a team-based multi-pronged and multi-stakeholder response.[5] The extensive work carried out by the Multidisciplinary Collaborative Primary Maternity Care Project (MCP2) and the Ontario Maternity Care Expert Panel (OMCEP) Report have identified key principles of effective team practice. This paper does not attempt to recreate these very comprehensive reports. Instead, we focus on the current challenges to the implementation of IPC and shed light on the steps that must be taken to enable IPC.

We provide a snapshot of the approaching crisis in maternity care and of the specific demand for midwifery care. The current need for midwives and the looming maternity care crisis is our starting point. The gap between need and care should drive IPC initiatives. The specifics of client need must be the primary drivers of any health policy initiative, including IPC.

We identify six recommendations that require immediate government action if IPC initiatives in maternity care are to be developed and implemented in a sustainable manner.

We also identify eight foundational elements that must be constructed by stakeholders to ensure the creation and long-term success of IPC initiatives.

In partnership with the Ministry of Health and Long Term Care and with maternity care stakeholders, and with adherence to core principles of collaborative practice, viable solutions can be identified and implemented in order to enable new IPC initiatives in maternity care in Ontario.

Maternity Care Needs

The AOM is concerned about the approaching crisis in maternity care in Ontario. The widening gap in care has been fed by the steady decline, over the past twenty years, in the number of family physicians participating in intrapartum care. Neither the fairly stable number of obstetricians, nor the current rate of increase of practicing midwives, has offset this dramatic loss. See Appendix 2 for the specific change in primary care providers.

National reports identify similar maternity care shortages in other provinces, illustrating both the extent of the problem and the difficulty in finding rapid health human resource "fixes" from other jurisdictions:

> "*…Although Canada has one of the lowest maternal-infant mortality rates in the world, Canada's primary maternity care system is facing a crisis and ... pregnant women and their babies are increasingly put at risk because access to appropriate care is compromised...*" [6]

The implications of fewer maternity care providers are further complicated by recent decisions taken by some Ontario hospitals to stop providing maternity care; too often within communities lacking local alternatives. Furthermore, this reduced access to care is occurring within the context of significant population growth, including an expected increase in Ontario's birthrate over the next two decades. The Ontario Ministry of Finance projects that Ontario's population will grow by four million (or 32.6%) to 16.43 million by 2031, resulting in an increase in births from 130,000 per year to approximately 157,000 per year in 2024-25.

IPC is an important response to unmet maternity care needs in Ontario.

Building the Foundation for Successful IPC Initiatives

1. Collaboration

Collaboration is an essential precondition for successful IPC. The Midwifery Model of Practice[7] contains explicit expectations outlining the fundamental role of collaboration between midwives, and between midwives and other providers. In addition, midwives' practices are underpinned by the primacy of women's participation in their own care, including the decision about choice of birthplace. Midwives are the only profession to mandate this degree of collaboration with clients. Collaboration has been and continues to be a key tenet for Ontario midwives. The AOM supports the Health Force Ontario statement on the principles of collaboration and calls for these principles to be central to IPC initiatives.

In addition, the MCP2 and OMCEP reports are invaluable in the development of new IPC initiatives, particularly in the guiding principles identified as essential for IPC in a maternity care setting. These key principles include:

- Care across the continuum of maternity and newborn care
- Equitable access to care as close to home as possible
- Pregnancy and birth as normal physiological process
- Regional coordination of services and access to high-risk care
- Empowerment and participation of women
- Family-centered care
- Continuity of care
- Informed choice
- Choice of birthplace
- Quality care to diverse and vulnerable populations

As critically important as these principles are in conceptualizing IPC, the challenge lies in the development and the sustainability of IPC initiatives. Indeed, as the OMCEP report makes clear, *"there are currently few established practices using integrated models of care – in part due to regulatory, liability and funding* barriers".[8]

The importance of collaboration is a theme appearing in many other reports on IPC, beginning with the Health Force Ontario Blueprint that states:

> "*The manner in which health caregivers deliver care should be based on the principles of collaborative practice. Communication, trust, confidence in oneself, confidence in other health care partners, autonomy, mutual respect and a feeling of shared responsibility are essential elements in collaboration.*"[9]

The literature also links a collaborative approach to improved outcomes, and greater understanding and respect between various health care providers.[10] Effective IPC teams will be built on a foundation defined by collaboration.

2. Visionary Approaches to IPC

It is because of the widespread recognition of the need for collaboration to forge and maintain successful IPC teams that the AOM cannot support concepts of team practice that are not collaborative. For example, such concepts include that health professionals work in hierarchical teams[11], a physician must be the clinical leader in IPC teams[12] or that a physician should be the only team member to decide when a referral is necessary.[13] It is important that as we move forward with team based practice we do so with a vision and commitment to collaboration as the core principle of IPC.

The midwifery model does not provide for routine shared care in normal low risk pregnancy and birth because it is generally unnecessary and would be an inefficient use of human resources and scarce health care dollars. Shared care is not a necessary component of effective collaboration but may be a component of a particular IPC initiative.

New IPC initiatives must be visionary and welcome midwives as team leaders in the provision of low-risk maternity care.

Given that IPC initiatives will introduce a new way of providing maternal and newborn care, the AOM recommends that the MOHLTC earmark specific funds to support IPC pilot projects in communities that possess both the need and the providers willing to participate. Pilot projects will enable thorough evaluation and relevant "lessons learned" for subsequent initiatives.

3. Planning and Community Responsiveness

IPC is an important reform but its success depends on how it is pursued. A rush to create team practices that are only loosely linked to client need are unlikely to succeed. IPC teams must be well planned and responsive to the specific needs of the communities in which they are located.

Many discussions in favour of IPC oversimplify the work involved in forming successful team practices and underestimate the conceptual leap between improved collaboration and the actual construction of a viable team practice.[14] Collaboration is the foundation of IPC, but considerable planning is also needed to form and maintain successful IPC teams.

The benefit of enhancing collaboration between providers is supported empirically and logically. The reality of unmet maternity needs throughout the province is the motivation to transform the advantages of collaboration into IPC teams that will enable women to access quality care closer to home. Failure to acknowledge the complexities of the transition between collaborative relationships and building and maintaining IPC teams could result in squandering the potential that this reform offers.

4. Regulation is Both a Barrier and a Facilitator

There are significant regulatory obstacles to IPC. However, some regulations are facilitators to IPC. It is important to recognize the difference. Some of the regulations governing the practices of providers contain elements that discourage rather than encourage IPC. For example, although Regulation 965 of the *Public Hospitals Act* has been amended to enable midwives to admit, discharge and write orders for women and newborns, constraints continue. For example, the *PHA* does not extend the right of due process or the right of appeal concerning hospital

credentialing or representation on the committees that determine the credentialing of midwives. As a result, midwives rarely sit on Medical Advisory Committees in the hospitals where they practice and this can result in unfounded restrictions on scope of practice and on the number of women who are able to access midwifery care. This inequity conflicts with the *Regulated Health Professionals Act* (RHPA) by placing midwives in a position where members of another profession 'supervise' their care and are gatekeepers to access. It is an acknowledged inequity that the College of Midwives and the College of Physicians and Surgeons agreed in 1994 needed to be changed.[15]

A related obstacle to midwives becoming full partners in IPC is the resistance on the part of some hospitals to change their by-laws allowing midwives to be MRP (most responsible provider). Thus, even when enabling legislation exists, some hospitals are refusing to make it viable within their own institutions. To illustrate the implication of these obstacles, the Ontario Midwifery Program calculates that in hospitals where midwives have privileges, 24% limit the number of midwives granted privileges and 18% limit the number of midwife-attended births. In addition, many midwifery practice groups are prevented from growing because of hospital credentials (admitting privileges) being denied or capped and this is impacting the growth of midwifery across the province.[16] To promote IPC, it is necessary to change the inequity within the *Public Hospitals Act*. It is imperative for hospitals to bring their by-laws up to date with regulatory changes, thus allowing midwives to practice and to practice to the broadest possible scope allowed by regulation within all hospitals that offer maternity services.

Just as important to the facilitation of IPC is the understanding that the RHPA is not a barrier. The self-regulation of providers through Colleges is not an obstacle to IPC.[17] Self-regulation protects the public. The client-protection advantages of self-regulation, including the benefit of peer review and oversight, are vitally important to maintain. However, College regulations must be adaptable to changing practice if it is to avoid becoming an impediment to IPC.

Ensuring regulations keep pace with changes in clinical practice will enable midwives to participate fully in IPC teams. Specifically, enabling midwives to prescribe from drug categories and to order appropriate diagnostic testing for conditions within their scope of practice are essential in ensuring that midwives continue to be able to respond to the individual needs of clients as primary care providers within a team setting.

The AOM recommends that the MOHLTC update the *Public Hospitals Act* to ensure midwives are guaranteed due process and right of appeal concerning hospital credentialling and representation on committees that determine credentialling. In addition, we call on the MOHLTC to direct LHINs to establish consistent guidelines for the integration of midwives into all hospitals that offer maternity care, including guidelines for credentialing and guidelines that ensure midwives are able to work to their fullest scope possible. Midwives must be able to work to their full scope in order to be fully integrated into hospitals and to fully participate in IPC models.

5. Multiple Models Required to Meet Specific Community Needs

IPC initiatives must target the specific needs of individual communities. The need for community-specific models appears in various recent reports on maternity care.[18] The reports argue that communities differ in their need for maternity care reform and, where needs are not being adequately met, these communities differ in what will best address their needs. These reviews also strongly advise that many Ontario communities are currently receiving excellent maternity care that needs to be protected in its current form.

> "*In many settings, existing models of care are working well and providing excellent evidence-based maternity care. These models need to be supported and maintained …[the] challenge is to preserve models that are working well, while encouraging change where needed*…"[19]

While core principles are important in guiding IPC development, meeting the particular and individual needs of the community are key. IPC reform must focus on specific community needs, with initial concentration on those communities and individuals who are suffering most acutely from unmet needs. [20]

IPC initiatives should begin in communities where there is a need but also in communities where there are providers who are interested and able to engage in IPC.

> *"[IPC] rarely happens or survives because it is mandated. It happens where conditions exist or are created that are conducive to experimentation with new ways of collaborating and where providers (as well as administrators, patients and families) decide to exploit these conditions. It is sustained because of the institutionalization of the underlying enabling conditions but more importantly, because experience demonstrates the advantages of interprofessional practice for both patients and providers*." [21]

The Integrated Maternity Care for Rural and Remote Communities (IMCRRC) project is one example of an initiative to bring maternity care to low-risk women and babies in rural and remote Ontario communities. Within the participating centres, providers, community members and clients collaborate to develop new ways for midwives, nurses and physicians to work together. The six participating communities are also engaged in ongoing evaluation in order to determine the benefits and any ongoing challenges within the practices.[22] These models and evaluations are useful examples for other potential IPC teams. Successful models lead to enhanced interest and even more success; a snowballing of improved maternity care for those Ontario residents who need it most.

6. Funding and Structure

The AOM acknowledges, as many reports suggest[23], that adequate funding models can enable IPC. Ontario midwives support the quality of care that is facilitated by our current model of

practice and enhanced by course of care funding. The course of care funding model enables midwives to provide comprehensive care throughout the pregnancy, birth and to six-weeks post-partum. This funding model facilitates significant time spent in direct client care, which in turn enables the achievement of high quality outcomes.[24] The Ontario midwifery course of care funding mechanism avoids the incentives that are often linked to funding models, such as fee-for-service, that reimburse providers for performing specific services. Fee-for-service systems pose barriers and disincentives to IPC.[25]

Physicians must be compensated for being available to midwives to provide back up for emergent high-risk care. Without acknowledgement of the importance of enabling low-risk providers to access high-risk care for clients when necessary, IPC and the viability of the maternity care system across the province will be hindered.

Midwives are leaders in low risk, normal births and it is important that they have direct access to specialist expertise when their clients need it. Funding that enables obstetricians to be compensated for providing on-call back-up to midwives is critical to promoting maternity care by low-risk providers.

In addition, funding barriers transform what should be a simple referral into a complicated process involving more providers, time and cost, than is necessary. The pediatrician is not currently compensated if she or he accepts a non-emergent referral from a midwife. Instead, the referral must be made by a family physician. If the mother and infant are without a family physician, they need to go through emergency to access specialist assessment and care, which means an even longer wait, a delay in care and a greater waste of time and money. Similar complications occur with other specialist consults, such as endocrinologists. These funding inefficiencies hinder the provision of timely care and deter the development of collaborative relations and the pursuit of IPC. Thus we strongly concur with the following OMCEP recommendation that:

> *"a system to compensate specialists fairly for consultations with primary care providers is a vital aspect of supporting low-risk and low volume approaches to care and innovative models of practice."* [26]

The development of alternative funding arrangements is key to the success of IPC initiatives. A process to identify communities in need, earmark funding, and subsequently develop interprofessional models and teams will ensure that women will be more likely to have access to appropriate care, closer to home. Flexibility is important and there are several potential funding combinations, many of which were outlined in the MCP2 report.[27]

While midwives are not interested in being funded on a fee-for-service basis, members of our profession are interested in pursuing other models, or combinations of models, that would enable midwives to be part of new IPC initiatives. Possibilities include salary, partial salary, project funding or sessional funding, each of which could potentially fit with a partial course of care funding model. We are optimistic that the growing number of physicians who are choosing alternative payment plan (APP) funding will provide more opportunities and options for IPC.

For example, obstetricians who were participants in an IPC proposal from a central Ontario community were willing to receive salary for the obstetrical component of their practice, while retaining the fee-for-service structure for the gynecological part of their practice.[28]

We look to the MOHLTC to earmark funds that will bring IPC to communities in need. We expect that the AOM and the College of Midwives of Ontario will be involved, along with other professional colleagues, in identifying suitable communities, models and funding mechanisms for IPC initiatives. We expect new IPC funding models to be transparent and to be guided by principles of equity and fairness.

The particular needs of individual communities should be the key determinant in the nature of IPC initiatives, but the workload and work/life experiences of individual professionals is also an important factor to the success of IPC.

The AOM recommends that the MOHLTC create funding mechanisms for compensating midwives involved in IPC models that are equitable both within new IPC models and also with midwives working in the current Ontario model. In addition, obstetricians must be compensated to provide on-call back-up for consultations and referrals from midwives. Physicians must be compensated to be available for high-risk transfer of care. Likewise, other specialists such as pediatricians or anesthetists need to be compensated for direct referrals from midwives.

7. Education

Much attention has been devoted to the need for collaborative experiences with other health care providers during professional education programs.[29] When other providers exclusively access their practice experiences in hospitals or community settings where midwives do not practice, the potential for IPC is reduced. Thus, there are ongoing and serious implications for a community when midwives are denied hospital privileges.

The limitations currently faced by midwives in Ontario hospitals, such as the denial of privileges, limits on scope of practice and/or the limit on the number of midwives granted privileges, interferes with the opportunities for nurses and physicians to understand how midwives practice. In addition, the decision by some of the province's teaching hospitals not to include midwifery care within their agencies also decreases the opportunities for midwives to demonstrate the collaborative possibilities.

Thus, one of our key recommendations calls for the MOHLTC in conjunction with the MTCU to earmark funds to enhance interprofessional education within the Midwifery Education Program for midwifery students, medical students, residents, nursing students and other health care providers. The MEP, at each of its three sites at Ryerson, McMaster and Laurentian, is an ideal group to provide interprofessional education with a specific focus on maternity care.

In addition, the AOM calls on the MOHLTC to fund birth centres for low-risk normal birth and as model sites of interprofessional education and practice. Interprofessional education is essential to the success of IPC and birth centres offer an ideal environment for providers to learn from, with and about each other.

8. Liability

All health care professionals share medico-legal risk. While there is risk when consulting with other providers, this has always been the case. It is important to keep in mind that there is also risk when health care providers fail to consult with one another.

A joint statement by the Canadian Medical Protective Association (CMPA) and the Healthcare Insurance Reciprocal of Canada (HIROC) provides several specific risk management recommendations for physicians and midwives within their statement (see Appendix 3).

More importantly, the joint CMPA/HIROC statement, fully supported by the AOM, underlines the necessity of consistent and meaningful communication among the members of an interprofessional team. It also underscores the significance of careful planning, negotiation, collaboration and evaluation of any and all health care initiatives, including IPC.

We believe that the answer to the fears of increased liability through collaborative practice is to increase the opportunities for professionals to encounter other professions during education programs and in various practice settings, including birth centres. Midwives are prepared to be full partners in bringing improved maternity care to Ontario communities. We look forward to realizing this goal in concert with government and with maternity care stakeholders.

Recommendations

Specifically, we recommend that the Ontario Ministry of Health and Long-Term Care:

- Earmark specific funds to support IPC pilot projects in communities that possess both the need and the providers willing to participate. Pilot projects will enable thorough evaluation and relevant “lessons learned” for subsequent initiatives.

- Update the *Public Hospitals Act* to ensure midwives are guaranteed due process and right of appeal concerning hospital credentialling and representation on committees that determine credentialling.

- Direct LHINs to establish consistent guidelines for the integration of midwives into all hospitals that offer maternity care, including guidelines for credentialing and guidelines

that ensure midwives are able to work to their fullest scope possible. Midwives must be able to work to their full scope in order to be fully integrated into hospitals and to fully participate in IPC models. Direct LHINs to offer incentives to hospitals that fully integrate midwives.

- Create funding mechanisms for compensating midwives involved in IPC models that are equitable both within new IPC models and also with midwives working in the current Ontario model. Adequately compensate obstetricians to provide on-call back up for consultations and referrals from midwives. Physicians must be compensated to be available for high-risk transfers of care. Likewise, other specialists such as pediatricians or anesthetists need to be compensated for direct referrals from midwives.

- In conjunction with the Ministry of Training, Colleges and Universities, earmark funds to enhance interprofessional education within the Midwifery Education Program for midwifery students, medical students, residents, nursing students and other health care providers. The MEP, at each of its three sites at Ryerson, McMaster and Laurentian is an ideal group to provide interprofessional education with a specific focus on maternity care.

- Fund birth centres for low-risk normal birth and as model sites of interprofessional education and practice. Interprofessional education is essential to the success of IPC and birth centres offer an ideal environment for providers to learn from, with and about each other.

Conclusions

The AOM supports the use of new models of IPC to make maternity care more accessible and closer to home for communities that are in need of maternity care services. Given that the needs of communities will vary, IPC models must be geared to meet the specific needs of individual communities.

The AOM concurs with the OMCEP recommendation that in order to improve the preparedness of providers to engage in collaborative practices, including IPC, there must be a renewed commitment to recognize maternity care "*...as an essential part of primary care...*" [30]

Many Ontario communities are currently enjoying high quality maternity care, including the fundamentally collaborative midwifery model. This is excellent, evidence-based care that needs to be maintained and strengthened. This is indeed our challenge and we trust that the MOHLTC, in concert with maternity care stakeholders in Ontario, will successfully take up this opportunity and ensure that all Ontario residents have access to high quality maternity care as close to home as possible.

Appendix 1:

AOM Definitions of Collaborative Care and IPC

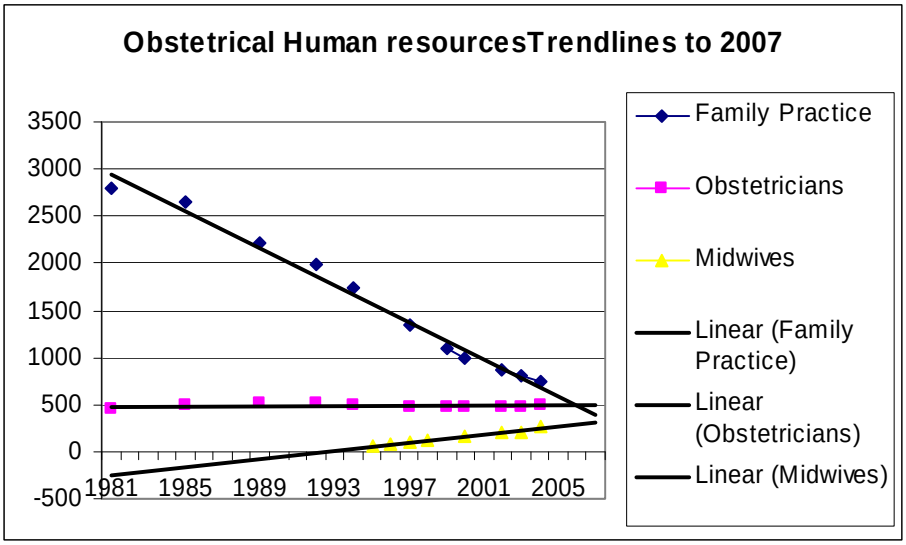
Collaborative Care: a cooperative and mutually supportive relationship characterized by respect for the contributions of all health professionals, trust, mutual support, excellent communication and coordination among providers, and absence of hierarchy. The contribution of each participant is based on knowledge or expertise brought to the practice rather than a traditional employer-employee relationship. The goal of collaboration is enhanced patient care. In maternity care, this can include collaboration among the same professionals, between different professionals within the same stage of care (i.e., antepartum, intrapartum or postpartum), collaboration with women and their families, collaboration with other providers outside the model, and collaboration with support staff.

IPC: IPC is used to describe a specific type of collaborative care which is team-based and where providers from different professions share responsibility for care for the same group of women and babies and may share on-call coverage as well. Individuals from the different professions work together, either in sequence or concurrently, to provide care to the same person or population. Usually these teams work in the same location, have a shared philosophy of care and/or protocols. There could be many models of interprofessional collaboration that would enable physicians, midwives, nurses and other health care providers to work together as part of a maternity care team. Successful models provide mechanisms for ongoing communication among caregivers, optimize participation in clinical decision-making within and across disciplines, and foster respect for the contribution of all professionals within the group.

Appendix 2:

Specific Change in Primary Care Providers

The following chart and table presents the specific changes in the number of providers within each professional group over the past twenty years; a clear illustration of the seriousness of the overall reduction in intrapartum practitioners in Ontario.



Number of Primary Care Providers Attending Births in Ontario

Year	1984/85	1993/94	1999/2000	2004/05
Family Physicians	2,658	1,734	990	751
Obstetricians	486	494	473	494
Registered Midwives	0	68	162	304
Total	3,144	2,296	1,625	1,549

Table: Stan Lofsky for the Ontario Medical Association[31]

Appendix 3:

Selected HIROC/CMPA Joint Statement Recommendations:

- Have appropriate and adequate professional liability protection and/or insurance coverage;
- Confirm the continuing appropriate and adequate professional liability protection and/or insurance coverage of the other members of the health care team;
- Be familiar with the scope of practice of each team member in the jurisdiction and institution in which they work;
- 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..."

Source: Joint Statement by HIROC and CMPA, Liability Protection for Midwives and Physicians, June 2007.

Appendix 4:

AOM Supported Key Principles of MCP2 and OMCEP

The Association of Ontario Midwives supports the following fundamental principles developed by the National Primary Maternity Care Committee of the MCP2 project:

- **Women-Centered**: Responsiveness and informed choice and decision-making for women. This model must respect the needs, goals and values of women and their families.
- **Quality maternity care**: achieved by the contribution of all care providers... based on equity of access to and integration of, services, timeliness, continuity of care, patient safety and valuing different providers' expertise.
- **Best evidence and practice guidelines**: commitment to care based on best evidence and practice guidelines.
- **Professional competence**
- **Commitment to the Collaborative Model**: willingness to devote time and energy to collaborative model and willingness to discuss differences openly.
- **Mutual Trust and Respect**: for each other's perspective and way of thinking
- **Shared values, goals and visions**: with a philosophy of childbearing as a normal physiological process.
- **Honest, open and continuous communication**.
- **Responsibility and accountability**: recognizing each profession's standards of practice.
- **Scope of Practice**: understanding and respect for different professions' scopes of practice.
- **Common protocols**: for clinical and administrative purposes.
- **Mutually Supportive Environment**: unified front and mutual support by team members.
- **Acceptance to discuss financial issues**: open and frank discussions.
- **Locally based**: women receiving primary maternity care as close to where they live as possible.
- **Effective, integrated regional provision of services**: To ensure women are cared for and give birth in the most appropriate environment, whether they have normal pregnancies or high-risk situations.
- **Knowledge of available services**: women and families must be informed of the range of services and supports available to them – especially in rural and remote areas where some aspects of care may not be available...[32]

The AOM also supports the Ontario Maternity Care Expert Panel's Guiding Principles for Maternity Care in Ontario as key tenets for IPC:

Woman and Family-Centered Care Principles

- Care across the continuum of maternity and newborn care
- Equitable access to care as close to home as possible
- Pregnancy and birth as normal physiological processes
- Regional coordination of services and access to high-risk care
- Empowerment and participation of women
- Family-centered care
- Continuity of care
- Informed choice
- Choice of birthplace
- Quality care to diverse and vulnerable populations

Principles of Service Provision

- Valuing maternity care providers
- Collaboration – respectful, seamless, interprofessional
- Provider preparation, competence and confidence
- Sustainable services

Principles of Provincial Stewardship and Coordination

- Provincial coordination of services
- Maternity care as part of primary care
- Alignment of system with determinants of health through other ministries
- Continuous evaluation and improvement
- Financial responsibility and accountability.[33]

The AOM concurs with the OMCEP recommendation that all interprofessional models must incorporate the following characteristics of collaboration:

- Open, honest communication
- Mutual trust and respect
- Understanding and valuing each other's perspectives and way of thinking
- Familiarity with/valuing each other's style and scope of practice
- Equality and shared power
- Professional competence
- Shared responsibility and accountability
- Shared decision-making
- Shared values, goals and vision
- Willingness to share information.
- Common approach and mutual support
- Willingness to devote time and energy to relationship
- Frank discussion and resolution of financial issues.[34]

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Endnotes

[1] Ontario Medical Association (2006). Response to the OMCEP report on Maternity Care in Ontario.
[2] A sampling of these reports includes: HealthForceOntario's Interprofessional Care Steering Committee (2007). *Interprofessional Care: A Blueprint for Action in Ontario;* Canadian Health Services Research Foundation. (2006). *Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada;* HealthForceOntario. (2006). *Proceedings Report for the Summit on Advancing Interprofessional Education and Practice*; Commission of the Future of Canada (2002). *Building on Values: the Future of Healthcare in Canada: Final Report.* November.
[2] For example, The Multidisciplinary Collaborative Primary Maternity Care Project, a joint initiative of the Association of Women's Health, Obstetric and Neonatal Nurses, Canada (AWHONN), the Canadian Association of Midwives, The Canadian Nurses Association, the College of Family Physicians of Canada, the Society of Obstetricians and Gynecologists of Canada and the Society of Rural Physicians of Canada, was funded by Health Canada's Primary Health Care Transition Fund, with the goal of reducing barriers to multidisciplinary collaborative primary maternity care
[4] For Example, the Ontario Maternity Care Expert Panel report, *Maternity Care in Ontario 2006: Emerging Crisis, Emerging Solutions*; Stewart, M; Smith, C., Brown, J.B., Trim, K., Freeman, T. & Kasperski, J. (2006). *Ontario Providers' Opinions Regarding Models of Maternity Care: Final Report for the Babies Can't Wait: Primary Care Obstetrics in Crisis*. Centre for Studies in Family Medicine of the University of Western Ontario and Ontario College of Family Physicians.
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[11] Ontario Medical Association. (2007). *Policy on Interprofessional Care.*
[12] Ibid*:* 8.
[13] Ontario Medical Association. (2007). *Comprehensive Primary Care Policy Paper*: 10.
[14] For example, HealthForceOntario's IPC Steering Committee's (2007), *Inter-professional Care: A Blueprint for Action in Ontario*, links research on the benefits of improved communication and coordination as indicative of the benefits of IPC.
[15] Ontario Hospital Association (1994). *Midwifery: The Integration of Midwifery Services Into Hospitals*. Publication #241: 4.
[16] Ontario Midwifery Program. (2007). *Hospital Integration Survey*.
[17] For example, Oandasan, I. et al (2005). Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada. Report funded by CHSRF and Health Canada, notes that "*Professional self-regulation has created additional boundaries among professions..."*: 15;
[18] The Multidisciplinary Collaborative Primary Maternity Care Project; Ontario Maternity Care Expert Panel report, *Maternity Care in Ontario 2006: Emerging Crisis, Emerging Solutions; Babies Can't Wait: Primary Care Obstetrics in Crisis*.
[19] OMCEP (2006) Executive Report: 21.
[20] AOM conducted several focus groups of our midwives from a broad cross section of communities and types of practices as part of the preparation of this document; a reflection of our belief that reform must be grounded in the practice experiences of those currently providing midwifery care.

[21] Lahey & Currie (op. cit.): 205-6.
[22] IMCRRC, research project supported by the Ontario Ministry of Health and Long-Term Care, Primary Health Care Transition Fund and Ryerson University Faculty of Community Services.
[23] For example, Deber & Baumann (op. cit.); OMCEP. Executive Report (op.cit.); Anderson, M., MCP2 (op.cit.).
[24] For example, Ontario Midwifery Program Evaluation; Maternity Experiences Survey (MES). A project of the Canadian Perinatal Surveillance System (CPSS reported November, 2007).
[25] Oandasan, I., Baker, G.R., Barker, K., Bosco, C., D'Amour, D., Jones, L., Klimpton, S., Lemieux-Charles, L., Nasmith, L., San Martin Rodriguez, L., Tepper, J., and Way, D. (2005). *Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada. Policy Synthesis and Recommendations*. Report funded by the Canadian Health Services Research Foundation and Health Canada: 16.
[26] OMCEP, Executive Report (2006): 26.
[27] MCP2 (2006) *Guidelines for Development of a Multidisciplinary Collaborative Primary Maternity Care Model*. Ottawa: 27-28.
[28] Alliston Model/proposal.
[29] For example, OMCEP, MCP2, San Martin-Rodriguez et al, op. cit., Oandasan, et al (op cit.) all speak to the importance of having collaborative experiences with other providers.
[30] OMCEP, Executive Report: 19.
[31] Lofsky S et al, 2005. Ontario Medical Association Position Paper: The Ontario Physician Shortage 2005: Seeds of Progress, But Resource Crisis Deepening
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[33] OMCEP. (2006) Executive Report: 11
[34] Ibid: 22.

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