Association of Ontario Midwives
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September 14, 2020

Claire Ramlogan-Salanga, President
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Dear Claire:

Re: Request for Feedback on a new Scope of Practice Guide

Thank you for the opportunity to provide feedback on the draft Scope of Practice Guide (SPG) as a replacement document to the Consultation and Transfer of Care (CTCS) standard. We appreciate the consultation process the CMO has undertaken on the CTCS. We share your concerns that the current standard does not adequately articulate the acts authorized to midwives by their governing legislation and welcome this opportunity to clarify the understanding of midwives' scope.

By clarifying the legislation that governs scope of practice, the SPG may eliminate many of the problems identified with the CTCS. We agree with the purpose of the guide stated as explaining midwives' scope of practice, affirming midwives' responsibility when care reaches the limits of their scope, and the process when a clinical situation falls outside of a midwife's scope. However, we think that the guide could go further in achieving this purpose. To achieve these goals, the AOM recommends revisions to the SPG to enhance its clarity and address some of our specific concerns. In short, we recommend that the SPG:

1. State in the introduction that the guide is intended to explain the midwifery scope of practice not only to midwives, but also to other health care professionals with overlapping scope, and to facilities that credential midwives;
2. Clarify the definition of "normal", avoid examples that do not explain the decision-making process, and avoid terms such as high risk and low risk;
3. Describe the step-by-step process, starting with the legislative framework, that midwives should apply to determine if care is within their scope, including using examples that demonstrate how this step-by-step decision-making process is applied;
4. Clarify "individual scope of practice" by explaining that midwives are primary care providers who use knowledge, skill, and judgement to make appropriate plans of care and to determine when to recommend a consultation or transfer of care;

5. Explicitly state that the CMO does not condone scope restrictions unless they serve the public interest and remove reference to "external factors".

Our comments below elaborate on the content we hope to see in the guide and point out a few concerns we have with the current draft.

1. Introduction to the SPG and Identifying the Intended Audience

We appreciate the CMO's acknowledgement that many midwives in the province face a constant struggle to practice in the manner intended by legislation. Misunderstandings of scope are, in part, caused by the flaws now recognized in the CTCS and other guiding documents. Misunderstandings have been further compounded by midwives' evolving scope and the CMO's evolving approach to midwifery scope. As the CMO has stated, the SPG risks compounding these challenges and misunderstandings if not as clear as possible.

Health care providers who have an overlapping scope of practice with midwifery are often empowered to require unnecessary transfers of care, against the interests and choices of individual recipients of care and against the public interest in health care system safety, cost and efficiency. For the SPG to be an effective tool to meet the objectives stated by the CMO the message must be clear that the public interest is best served by the scope of practice of midwifery, as defined in law, regulations, and standards.

To address these concerns, we recommend that the introduction to the SPG contain background information about the evolution of the midwifery scope of practice through regulatory changes, and that it highlight the importance of the legally defined scope of practice in serving the public interest. The target audience of the guide should explicitly include other health care professionals, especially those with scope of practice overlapping midwifery scope, and health care facilities and institutions, such as hospitals that credential midwives.

2. Clarify the Definition of "Normal" in the Context of the Scope of Practice Scheme

The SPG draft clearly states: "Normal applies to the overall health status of the individual and does not necessarily rule out the presence of a specific condition or indicate the complete absence of abnormal." **We recommend that the CMO build on this definition of normal by explaining that the parameters of "normal", as intended in the legal description of midwifery scope, are established through the controlled acts, drugs, and tests legally authorized to midwives.**

In providing examples of normal and abnormal, section 3 of the current draft of the SPG repeats some of the problems found with the CTCS. Providing examples of care that are in scope or out of scope is only useful if there is an explanation of the reasoning that leads to the conclusion – what acts, drugs and assessments needed to manage the condition are authorized to midwives. Later in the SPG, a decision tree is provided, but the examples provided in section 3.1 do not follow the logic of the decision tree. Equating normal with low risk and not normal with high risk does not clarify scope as there is no widely accepted definition of these terms. Including the excerpt from the ICM statement could also cause confusion, because if the reader looks to the ICM document the quote is drawn from, the scope described is significantly different than the scope of Ontario midwives.

Instead, we would recommend that all examples go through the entire process of a decision tree, such as the one outlined in the section that follows, below. Rather than stating that something is outside of scope, this would clearly explain to midwives why and enable them to apply the same process to other clinical presentations.

3. Clarify the Steps and Considerations Needed to Define Scope and Providing Examples

We found Table 1 in section 3.2 contained useful information, but the formatting and presentation made it difficult to read and comprehend the contents. **We would suggest that the CMO consider a summary of the information in the body of the document with the table as an appendix.** As noted previously, we would also suggest using examples that show the process for determining if care is within scope.

We would recommend that the examples illuminate the steps in a decision tree as follows, and replace the decision-tree in Appendix A:

1. Is the person who will receive care pregnant, in labour, postpartum or a newborn? (In a few exceptional situations, assessments can also be performed for the partner of an individual who is pregnant, in labour or postpartum, and these are mentioned in the draft SPG.)
2. Based on the midwife's knowledge, skill and judgement, does the individual's history, physical findings (including lab results and diagnostic imaging), and/or symptoms lead to a diagnosis or suspicion of a health condition which could negatively impact their health? If so,
    - Are midwives authorized to perform the controlled acts required to assess and manage the condition?

- Are midwives authorized to order the required laboratory and diagnostic imaging assessments?[1]
- Are midwives authorized to prescribe and/or administer the required medications?

If the answer to these questions is yes, then the management of the condition is within the legal midwifery scope. A negative answer to any of these questions requires the midwife to recommend a consultation or transfer of care to a provider who has the scope of practice and the necessary knowledge and skills to provide the care needed for health and safety. Repeating the steps in the above decision tree throughout the course of care would also guide the timing of a consultation or transfer of care.

The section titled *When an Individual's Clinical Condition Falls Outside the Scope* lacks some of these elements of the decision making process. In particular, involving a consultant to manage one aspect of care is often a way to provide excellent, safe care with greater continuity for the individual. Further, a transfer may occur during a particular time during the care continuum, such as for a caesarean delivery, but care may return to the midwife during the postpartum period.

We recommend using detailed examples which go through all the decision making steps described above to determine legal scope, and then adding additional factors to consider to determine if the best plan is for the midwife to provide care, or recommend a consult or a transfer of care. One of the factors to be considered in recommending a consultation or transfer of care is the individual scope of practice of the midwife.

4. Clarifying the Meaning of Individual Scope of Practice

This section of the SPG clarifies how midwives' individual knowledge, skills, and judgment affect their scope. It would be useful to clarify that midwives, as primary care providers and regulated healthcare providers, are responsible for determining the limits of their own knowledge, skills, judgment. **We would also recommend using different language to refer to these individual "scope" of practice.** It would be clearer to the reader if the term scope of practice were only used to refer to the legislative scope and if other language were used to refer to individual competencies.

[1] We note that the Ministry has yet to adopt the CMO's recommendations to amend the regulation defining the laboratory and diagnostic investigations midwives may order. We would hope that these amendments be made as soon as possible because the current list is outdated, as the CMO is aware.

We recommend that section 3.3 on individual scope of practice include a statement and explanation that midwives cannot limit their scope of practice in ways that contravene the laws of Ontario or Canada. For example, a midwife cannot use discretion over individual scope of practice to exclude individuals from care based on one of the protected grounds in the Ontario Human Rights Code. Guidance is also needed for midwives who may choose not to provide a service based on personal conscience, such as abortion or contraceptive care. The discussion of individual scope of practice is an opportunity to support understanding that the legal requirement for effective referral for these services must be carried out.

We would also ask that this section clarify that a midwife's individual scope of practice does not limit choices that can be made by an individual seeking care. Midwives must provide all individuals in care with information about all available care options, not only those care options which the midwife has the ability to provide, or which align with the midwife's own conscience or choices. If the individual chooses an option which the midwife is not willing or able to provide, the midwife must expeditiously and respectfully facilitate access for the individual to receive the chosen service.

5. External Factors That May Influence Scope of Practice

We are very concerned that section 3.4 on "external" factors blurs the definition of regulated scope and is highly subject to misinterpretation. Its inclusion in a CMO guideline also implies that the CMO recognizes these "external factors" as legitimate restrictions. **Section 3.4 contains several statements that are either factually incorrect or against the public interest, or both; we recommend that this section be removed entirely.**

The term "care setting" would be much clearer than "external factors" as something that influences decisions about what care to provide and when to recommend other care. This term recognizes that different models of care, such as APAs, and different community needs, such as rural versus urban settings, are considered when making a decision about which services are provided. However, as the CMO states in the SPG– scope is defined by legislation not care setting. As written, this section implies that external factors may limit scope of practice, which seems to contradict the guide's emphasis on the legislative definition of scope.

The discussion and explanations should leave no room for a reader to believe that the CMO supports or condones arbitrary scope restrictions by institutions not based solely on the interests of the individuals receiving care.

Regarding access to health care resources, the statements and example given in this section confuse the statements made in section 2 of the SPG about the scope of practice scheme. The Laboratory and Specimen Collection Centre Licensing Act is part of the legal framework that defines midwifery scope of practice. Referring to it as an "external factor which may influence

scope of practice" is confusing. Lack of authorization for the tests is not a "resource" issue, it is part of the regulated legal framework of midwifery scope of practice.

Miscellaneous Comments

In addition to the comments above, we have the following more specific comments and recommendations:

- **Clarify that the word "woman**" does not permit excluding a person from care because the person does not identify as a woman.
- **Clarify that "client" means any person receiving midwifery** care, not only individuals who have been taken into care in the traditional model of care in Ontario. This would ensure that the SPG captures recipients of episodic care, care provided to physician clients, and individuals who attended an intake visit but did not continue in midwifery care.
- With respect to newborns, it would be useful to add that the **birthing parent of the newborn does not need to be in midwifery care**.
- The explanation of services that can be provided between 6 weeks and 8 weeks postpartum is a potential source of confusion. Readers may not connect the language of the controlled act of diagnosing and the difference in scope after six weeks. **A clear explanation of why and how scope is different between 6 and 8 weeks would help alleviate this**. Questions will also arise about how a midwife can prescribe medication or recommend treatment for a condition after six weeks postpartum without diagnosing.
- **The clarity and utility of Section 2, the legislative context in Ontario, could be enhanced** by a diagram or concept map that illustrates and summarizes the relationships between the elements of the scope of practice scheme. **We would also recommend mention of waivers and APAs**, as these essentially expand midwives' scope in some settings.
- The statement in section 3.4 about the funding model does not accurately describe the Ontario model. The funding formula does not require midwives to provide prenatal, intrapartum and post-partum care; rather it funds midwives for that full basket of services. Increasingly, Ontario midwives are practicing in a variety of care models, which are accounted for in the funding options available. And the funding model should not define scope of practice. **We would recommend removing any reference to the funding model.**

The Scope of Practice Guide is a much needed tool which can help midwives and stakeholders understand the intention of the legal regulatory framework, and apply it to provide safe, quality care. We appreciate the opportunity to provide input, and we look forward to continuing our dialogue on this and other College guidance documents. Thank you for taking the time to

carefully consider this letter. Please do not hesitate to contact us for any clarifications or for further input.

Yours truly,

Jasmin Tecson, RM, President

Cc: Kelly Dobbin, CEO & Registrar, CMO
Juana Berinstein, Interim Executive Director, AOM
Allyson Booth, Director Quality and Risk Management, AOM