College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

CONSULTATION PAPER:
Standards Review: Phase 2

August 2020

Purpose

In 2016, the College adopted a principles-based approach to the development of the standards of practice; an approach that relies on broad principles, rather than rigid rules that midwives must follow. Adopting a principles-based approach required a review of all of the College's existing standards in order to revise or rescind those with prescriptive rules that limited midwives' ability to exercise clinical and professional judgment in their midwifery practice. The first part of this review, completed in June 2018, resulted in rescinding a number of standards, such as External Cephalic Version and the Ontario Midwifery Model of Care. At this time, the Professional Standards for Midwives was implemented. We are now completing Phase 2 of our standards review after spending the past two years working on the remaining recommendations from Council including the proposed rescinding of the Consultation and Transfer of Care Standard (CTCS) and the development of a guide about the midwifery scope of practice.

To complete Phase 2, we are requesting feedback about Council's decision to:

- Rescind the Consultation and Transfer of Care Standard (CTCS), implement the Midwifery Scope of Practice Guide, and add a standard to the Professional Standards for Midwives that sets minimum expectations for midwives after a transfer of care.
- Rescind the standard Delegation, Orders and Directives and propose changes to the Professional Standards for Midwives.
- Rescind When a Client Chooses Care Outside Midwifery Standards of Practice and make changes to the Guideline on Ending the Midwife-Client Relationship.

An implementation date for rescinding the standards has not been set and will be based on the feedback from this consultation as well as consultations with the Association of Ontario Midwives (AOM) and the Midwifery Education Programs (MEP). There will be sufficient time for midwives and midwifery practice groups (MPG) to adjust prior to implementing the proposals.

This consultation has been divided into three sections based on the three standards proposed for rescinding. Please review each section and any corresponding attachments. In order to respond to rescinding the CTCS, for example, it is important to read the Midwifery Scope of Practice Guide. Each section describes the College's rationale for rescinding the standard and describes where important information from the standard will be placed when it is rescinded.

This consultation will be available until **October 10, 2020.** We will hold a webinar in the fall to discuss the feedback from the consultation and to answer questions and address concerns about our proposals.

Thank you for participating in this important consultation.

Consultation and Transfer of Care Standard

The Consultation and Transfer of Care Standard (CTCS) contains a list of clinical conditions that dictates when midwives must consult with, or transfer client care to, another health care provider. The CTCS has been developed to define the midwifery scope of practice by listing the clinical conditions that are considered outside the scope of practice or conditions that midwives cannot manage because they do not have access to the tests or treatments to do so. The CTCS, however, does not articulate what midwives are authorized to do by their governing legislation.

Why Are We Proposing to Rescind the CTCS?

As a standard, the CTCS must set minimum expectations that must be met by any midwife in any setting or role. The CTCS, however, does not establish a minimum standard of behaviour but rather details when midwives must initiate a consultation or transfer care. The result is an incomplete list of clinical indications that may, or may not be, in the scope of midwifery practice with some indications that are vague and some that are explicit. The CTCS leaves very little room for clinical judgment.

Prior to proposing rescinding the CTCS, it was important to understand how the CTCS works in practice and what gaps in information might result once rescinded. In May 2019, we held a consultation with midwives about the CTCS where we asked for feedback about using the CTCS in midwifery practice, how the CTCS contributes positively and negatively to interprofessional relationships, and if it is in the best interest of clients and midwives to have this list of clinical indications that tells midwives when to consult or transfer care. There was both positive and negative feedback about the role of the CTCS in midwifery practice. In general, feedback from the CTCS consultation supported the proposed recommendation to rescind the CTCS. More about the findings from that survey are described below.

May 2019 Consultation Results

In total, there were 104 midwives who responded to the questionnaire. Responses showed that the CTCS is prescriptive but not necessarily effective in interpreting the midwifery scope of practice or supporting interprofessional relationships. Responses suggest that the CTCS has little to do with understanding scope and more to do with the relationships between midwives and obstetricians. In fact, many of the positive responses to the document focused on how the CTCS provides clear guidance for other health care providers including hospital staff. There was also little mention of the CTCS working as an advocacy tool for clients and its role in client care was rarely mentioned unless it was to express frustration with what are perceived to be unnecessary transfers of care. From the analysis, the following key themes emerged:

Key Theme One: The CTCS undermines midwives as primary health care providers

1. The CTCS is meant to set parameters around the clinical conditions that are not in the scope of practice but instead defines when to consult and when to transfer care. Many respondents felt this prevented them from practising autonomously and collaboratively.

   I lose my autonomy as a practitioner when I have to stick to a list. Also, it makes a midwife seem less skilled than we are in the eyes of other health care practitioners.

2. The CTCS places the provision of care in a hierarchy where consultants are at the top and midwives are at the bottom. The CTCS puts the expert knowledge in the hands of the consultant, which means a physician will never consult with a midwife even though a midwife may have expertise in a particular area.
3. The CTCS can lead to midwives appearing and feeling incapable and unprofessional. Some respondents felt it was demeaning for midwives to follow a list rather than apply their skills and training, and felt the list suggests midwives are not competent to determine when to consult and transfer care. This is exacerbated when consultants question why a midwife has to consult and the response is that they must do so based on a list the College has produced. This can lead to undermining the confidence of midwives.

   [The CTCS] is prescriptive and is a signal to consultants that we are incompetent if we have to consult or transfer care for low-risk issues.

4. The CTCS prevents midwives from using their clinical judgment. The CTCS requires consults and leads to unnecessary transfers but can also lead to midwives keeping care when they are not comfortable with the situation. In the former, continuity is disrupted and in the latter midwives are managing situations they do not feel capable of managing. Both outcomes are not in the best interest of clients.

   A midwife as an autonomous primary health care provider should have enough sense to know when something is beyond their experience level… if I am not comfortable with managing inductions (yet) then I need to consult or transfer care.

Key Theme 2: The CTCS leads to interprofessional conflict

1. While some respondents believe the CTCS supports interprofessional care, encourages dialogue between midwives and consultants, and establishes clear expectations about when to consult and transfer care, more respondents feel it is a barrier to interprofessional care and can actually create conflict between midwives and physicians, hospital staff and administrators. For example, tension and disagreements result when a consultant transfers care even though a midwife is only requesting a consultation. The CTCS can also lead to disagreements when midwives, nurses, and obstetricians do not agree on the interpretation of it. At the same time, some consultants are frustrated because midwives cannot manage certain clinical conditions when they should have the knowledge and skills to do so or are constrained by the list and so physicians must assume care.
2. Conversely, some care providers think that anything that is not on the list is in scope and this can lead to feelings that midwives are not practising to their full scope.

   [The CTCS] doesn't contribute to interprofessional relationships and makes it difficult to advocate for clients.

Key Theme 3: The CTCS undermines person-centred care

1. The focus of the document is on consultations and transfers of care rather than on the provision of care. Using the CTCS means clients are not the primary decision-makers but in many cases, the consultant ends up being the primary decision-maker for midwifery clients. This undermines the principle of person-centred care. In addition, unwarranted consultations and transfers of care undermine continuity of care.

   I think [the CTCS] does result in increased consultations with physicians that may not be warranted/useful to clients.

   I don't think the public is best served in this manner. I think the public is best served when we are free to use our clinical judgement and consult or request a transfer of care when the clinical situation dictates.

Key Theme 4: The CTCS is open for interpretation

1. While some respondents feel the list of indications provides clear boundaries about what midwives can and cannot do, many feel the list is not inclusive, not clear and is open for interpretation. The list also does not account for community differences or differences in the skills and experiences of midwives.

   *It's a very vague and misleading document. Can't make sense of why things are within **[**the**]** scope of practice, and I still need to consult.*

   If we are adequately trained and understand what is within our scope of practice and what is within our knowledge, skills, judgment, we should not be bound by a list.

Key Theme 5: Newer Midwives Need Guidance

1. Numerous respondents believe a list of clinical indications is good for midwives new to the profession and that a list should exist for new midwives but is not required for experienced midwives.

After [more than 10] years of practice I think a list is not useful - when I was a newer midwife I did find it useful - the list was a means to tell the [obstetrician] "my college guidelines are to request a transfer of care" - frankly now I just say " I want a transfer of care."

The consultation shows that the CTCS is used not as a helpful tool for midwives to interpret their scope as outlined in the legislation but as a tool for showing other health care providers what midwives are allowed to do as well as what they are not allowed to do. It is worrying that midwives, as primary care providers with numerous controlled acts, including prescribing drugs and ordering laboratory tests, must defend their scope of practice with colleagues in the health care system. It does suggest, however, that midwives need clear guidance about the midwifery scope of practice for themselves as well as for their clients and their colleagues, and a list of clinical indications cannot define the profession's scope of practice. This need for guidance is particularly important for new midwives in their first few years of practice.

What Will Replace the Consultation and Transfer of Care Standard?

1. **Scope of Practice Guide**

   The College has developed a Scope of Practice Guide that outlines what midwives are authorized to do by their governing legislation and describes the following:

   - The difference between a legislative scope of practice and an individual scope of practice
   - The controlled acts authorized to midwives
   - How to manage care that is outside the scope of practice
   - Factors that influence a midwife's scope of practice.

   Please click here to read the proposed draft of the Scope of Practice Guide.

2. **An additional standard added to the Professional Standards for Midwives:**

   The CTCS has a requirement that: ***After a transfer of care has taken place the midwife shall remain involved as a member of the health care team and provide supportive care to the client within the scope of midwifery***. This requirement in the CTCS will be replaced with the following standard to be added to the Professional Standards for Midwives: ***Collaborate with the MRP after a transfer of care, to provide care that is in the best interest of the client and the newborn.***

While the CTCS will no longer be a standard of the profession, midwives and midwifery practice groups (MPG) may choose to incorporate content from the CTCS into a practice protocol or use it to guide their practice.

We believe the public will be better served by midwives who are practising according to their legislative scope of practice outlined in the *Midwifery Act, 1991* and other pieces of legislation that govern the midwifery profession, rather than practising according to the non-exhaustive list of clinical conditions written into the CTCS. We also believe that midwives are ready for this shift.

Delegation, Orders and Directives Standard

The Delegation, Orders and Directives Standard provides definitions of delegation, orders, directives and teaching and contains information that is included in other College documents.

Why Are We Proposing to Rescind Delegation, Orders and Directives?

Council approved rescinding the Delegation, Orders and Directives standard because it overlaps with the Professional Standards for Midwives.

What Will Replace Delegation, Orders and Directives?

With the addition of several new standards and the definitions of delegation, order and directive in the Professional Standards for Midwives, we believe no information will be lost, and that the standards about delegation will actually be strengthened.

The following new standards will be added to the Professional Standards for Midwives:

Current standards	Additional proposed standards
Standard #31: Be accountable for your decisions to delegate and accept delegations of controlled acts by:	
31.1. delegating acts only to individuals whom you know to be competent to carry out the delegated act, and who are authorized to accept the delegation 31.2. delegating only those acts you are authorized and competent to perform 31.3. accepting only delegated acts that you are competent to perform. 31.4. ensuring the client has provided informed consent to the performance of the delegated act	31.5. delegating controlled acts only when you have an existing relationship with the client for whom the controlled act will be delegated 31.6. never delegating a controlled act delegated to you by another health care provider (sub-delegation) and never accepting delegation from an individual who has been delegated to perform a controlled act themselves 31.7. documenting in the client record who you received the delegation from or to whom you delegated and the controlled acts that have been delegated.

The following new definition will be added to the Professional Standards for Midwives (under Glossary)

Current Definition of "Delegation"	Proposed New Definition of **"**Delegation**"**
Delegation means a process where a regulated health professional who is authorized to perform a controlled act, as defined under the *Regulated Health Professions Act, 1991*, designates that authority to someone else who is not	***Delegation*** means a process where a regulated health professional (the delegator) who is authorized to perform a controlled act, as defined under the *Regulated Health Professions Act, 1991*,

authorized to perform that controlled act.	designates that authority to someone else (delegatee) who is not authorized to perform that controlled act. When an act is delegated, both the delegator and the delegatee are accountable. Delegation is carried out by either a direct order or a medical directive: A direct order provides the delegatee with authority to carry out a medical procedure on one specific client and occurs after the client has been assessed by the delegator. A direct order can be written or verbal and provides the details required for the delegatee to carry out the procedure. A medical directive provides the authority to carry out a medical procedure or series of procedures for any client as long as clinical conditions set out in the directive exist and are met. Medical directives are written in advance.

When a Client Chooses Care Outside Midwifery Standards of Practice

When a Client Chooses Care Outside Midwifery Standards of Practice sets out the requirements for midwives working with clients who choose care that falls below the midwifery standards of practice in non-emergency situations.

Why Are We Proposing to Rescind When a Client Chooses Care Outside Midwifery Standards of Practice?

Council approved rescinding the standard When a Client Chooses Care Outside Midwifery Standards of Practice because the Professional Standards for Midwives adequately addresses midwives' obligations when a client chooses care below midwifery standards. These standards include providing information so that clients are informed when making decisions about their care; making efforts to understand and appreciate what is motivating clients' choices; supporting clients' rights to accept or refuse treatment; and never abandoning a client in labour. In addition, the Professional Misconduct Regulation under *the Midwifery Act, 1991* sets out circumstances under which ending a midwife-client relationship does not constitute an act of professional misconduct.

What Will Replace When a Client Chooses Care Outside Midwifery Standards of Practice?

The College's Guideline on Ending the Midwife-Client Relationship, implemented in October 2018, provides guidance on when and how to end the midwife-client relationship. The guideline will be revised to provide additional guidance on organizing health care services for a client once they are discharged from midwifery care. With the addition of this information, which will be added to the guideline in the fall of 2020, we believe no gaps will be left when this standard is rescinded.